Mental Welfare Commission for Scotland

Report on announced visit to: Leverndale Hospital, West of Scotland Mother and Baby Unit, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 24 January 2023

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

The West of Scotland Mother and Baby Unit (MBU) is located in Leverndale Hospital and is a regional unit with six beds and serves the west of Scotland. The MBU receives admissions from Dumfries and Galloway, Ayrshire and Arran, Greater Glasgow and Clyde, Lanarkshire and Western Island Boards. It may also receive admissions from Forth Valley and Grampian Health Boards who can spot purchase beds when necessary and the unit may also receive boarding patients when Scotland's other MBU located in St John's Hospital, Livingston is full. The West of Scotland MBU unit building has a community perinatal team, offering outpatient clinics and outreach support for women living in Greater Glasgow and Clyde located on the first floor. The MBU accepts referrals from women at any stage of their pregnancy and during the first postpartum year.

On the day of our visit there were no vacant beds. We last visited this service on 29 November 2021 and made recommendations about adapting the functions in the EMIS, to facilitate the recording and review of care planning documentation and to review access policies to the ward for family members. The response we received from the service informed us that, firstly the unit's senior charge nurse had met with programme leads from EMIS and a short life working group was set up to facilitate the shift of remaining paper case records onto electronic templates in EMIS, specific to the perinatal service. The short life working group's activity remains ongoing. We were then told that in relation to second recommendation that by May 2022, the unit was able to facilitate one person (father/partner/carer) visiting the patient area on the ward.

On the day of our visit we were told that there were no restrictions on visitors to the ward and no alteration to the routine admission or pass process for patients, as a consequence of Covid-19 infection control measures. We wanted to follow up on our previous recommendations and also to hear how patients and staff have managed throughout the pandemic. We wanted to find out whether the unit has experienced any difficulties with staffing levels as we are aware from our various visits across Scotland that staffing in mental health services has become a source of concern due to difficulties in recruiting or retaining staff.

Who we met with

We reviewed the care of all six patients, one of whom we were able to meet with in person. The remaining patients were unfortunately unable to speak with us for a number of different reasons.

We spoke with the senior charge nurse, one of the charge nurses, and the ward occupational therapist during our visit.

Commission visitors

Dr Helen Dawson, medical officer

Anne Craig, social work officer

What people told us and what we found

Care, treatment, support and participation

Care records

The MBU has particular needs in relation to patient records, documenting information regarding the care and treatment of both the mother, who is regarded as the identified patient and also recording information about the mother's baby, who usually is also cared for in the ward. The case notes of the mother are primarily located in the electronic system, EMIS and work has begun to try and ensure all case records that are still held in paper format, are able to be converted to an electronic equivalent, to minimise risk of fragmentation of note keeping. We saw evidence of this during our visit with paper care plans now being scanned and uploaded onto EMIS, which provided improved coherence to the patients' case notes. However, we noted a small number of minor errors that had occurred in the process of scanning and uploading the documents. We raised this with the senior nurses during our visit. We learned that the notes regarding the baby/infant are located in a separate electronic system 'child-EMIS' although all nursing staff have access to both systems. We were also told that at the multi-disciplinary team meeting, information from both sources was used to inform the meeting and the decisions made there. Integration of notes is important to ensure that there is a holistic and comprehensive view of any patient and to ensure that the assessment of any risk regarding the mother and child is sufficiently informed. Having notes in different locations presented a risk of notes going missing or being overlooked and we look forward to progress on this when we next visit.

Admission documentation

In reviewing patients' files we found evidence of good record keeping with admission documentation that used an admissions proforma to support information gathering and recording. Information relating to the admission was clearly laid out and in general, easy to navigate.

Care plans

We found the care plans to be of a good standard and they became more individualised and person-centred as they progressed. We saw folders with copies of the patient's care plan kept in the patients' bedrooms and we were told that care plans are discussed and shared with the patients throughout admission. In the case notes we obtained evidence of this with reviews undertaken with the mothers on a regular basis. Piloting of the ways in which patients are able to evaluate their own care plan had provided feedback that the ward team had found helpful when further developing inclusion of patients in their care. We found evidence of regular evaluation of progress of care plans and examples of discharge planning undertaken from the very early days of admission, with work to establish contacts with community services who were to be involved post-discharge.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Risk assessment

All patients had a clear and comprehensive risk assessment (CRAFT) in place and we saw evidence that this had been updated and informed the relevant care plans, when appropriate. Risk assessment completion and review formed part of the unit's ongoing monthly audit processes for patient records to support the high standard in record keeping and care.

Multidisciplinary team (MDT)

The unit has benefitted from increased resources following the recommendations of the *Delivering Effective Services Report 2019*, which in 2020 resulted in a substantial increase in staffing levels in the unit. Key areas of expansion has taken place in ward nursing staff, nursery nurses and a nurse therapist post, in line with the recommendations. In addition to the psychiatry and nursing staff, person-centred care was also enhanced by input from the unit's own social worker, clinical psychology, physiotherapy, occupational therapy, health visitor, nursery nurses and a parent-infant therapist. A GP visits regularly to provide care for the babies and in the past six months two peer support workers have joined the clinical team also.

Every woman was provided with a named nurse and nursing associate upon admission. A key challenge in a clinical team, with such a diverse range of staff supporting either mother or baby individually or jointly, was the need for role clarity and good communication. As the clinical team has expanded, we were told this had developed incrementally and is an ongoing process. The regular multidisciplinary meetings were key to support integration of activity in the unit and also with community services. Each week every patient was invited to the ward round and asked who else they would like to attend (either in person or via teams).

We were told that the use of microsoft teams, during the pandemic lockdown, to host the multidisciplinary meetings, had proved beneficial. There was greater participation and involvement from external agencies experienced, who otherwise would not have been able to travel to the unit and participate in the meetings; this practise has continued.

Use of mental health and incapacity legislation

On the day of our visit very few patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The files that we reviewed had the appropriate paperwork in place regarding patients who were being treated under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the documentation was easy to locate in the patient files.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. For the patients who were detained at the time of our visit, all authority for treatment was in place.

We were told that urgent mental health officer (MHO) cover for the ward has been provided by Glasgow health and social care partnership which we considered to be important. Given the regional nature of the unit, with many patients coming from areas far from Glasgow, access to MHO involvement would be have been very difficult on an emergency basis. We were told that after any initial urgent involvement of Glasgow MHOs this role was then passed

onto the patient's local area authority, who were able to remain in contact after discharge if appropriate.

Rights and restrictions

Exit from the ward was facilitated via a buzzer system and door closing mechanism; it was not locked from the inside. Access onto the ward was more controlled and all access was gained via the unit's reception area and switch card system.

Patients were provided with written information about the unit, their hospital stay and their rights at the time of admission and which was also available in their rooms. The unit has previously produced an online virtual tour of the unit that was available on NHS GGC's website. This introduced the unit and helped mothers to find out about the unit prior to admission. We found the information provided to patients to be attractive and of a high standard with a range of topics considered and included.

Patients were referred to advocacy on an individual basis and information given to patients about advocacy and their rights to this.

We were told that over the past year Scottish Government funding has been made available to support the travelling expenses and meal and accommodation costs of close family or carers visiting the unit. We heard that there had been good uptake of this, including amongst Glasgow patients. Supporting visits in this way has encouraged and supported contact between immediate family members.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

The ward has a good range of activities undertaken by various professionals available throughout the day and evening. We were told that particular areas of staff interest were encouraged, developed and promoted to enrich the activities and resources available to patients and their babies on the ward. Activities were discussed on a daily basis in meetings with nursing staff, and participation was recorded. The ward had a number of attractively designed noticeboards with organised activities displayed and information about various aspects of health, across various locations, to facilitate ease of access and promote information sharing whenever possible.

The physical environment

The MBU is located in a purpose built two-storey building in Leverndale Hospital. It was a light and spacious ward, located on the ground floor, with the perinatal service occupying the remainder of the building. The ward overlooks a private garden, pleasantly stocked with plants and areas to sit in a range of weathers. There were a number of recreational areas of varying size in the ward where mothers and babies could relax and spend time together or with others. Each of the six bedrooms provided en-suite facilities and had a cot. One bedroom has facilities

for disabled access. A nursery was situated at the centre of the unit and there was a separate baby-feeding kitchen, baby bathroom and laundry facilities.

The unit's layout enables staff to observe mothers and their babies unobtrusively. The open plan lounge was large and bright with a dining area and looked out over the garden. A family room and separate play room provided space for individual and group activities.

The ward environment appeared clean and uncluttered. It was in good decorative order and was welcoming in appearance. There were no issues reported with respect to noise levels and light levels and the heating and ventilation appeared appropriate for an environment catering to the needs of babies.

Summary of recommendations

The Commission made no recommendations, therefore no response is required.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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