**Mental Welfare Commission for Scotland**

**Report on announced visit to:**

Leverndale Hospital, Ward 2, 510 Crookston Road, Glasgow, G53 7TU.

**Date of visit:** 31 May 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.

Ward 2 is a 15-bedded, mixed sex ward comprising of continuing care beds for patients with severe and enduring mental health problems and was managed as part of the rehabilitation service in Leverndale.

We last visited this service on the 13 May 2021 and made four recommendations. These included the management and review of Do Not Attempt Cardio-Pulmonary Resuscitation certificates (DNACPR's), maximising the use of the therapeutic kitchen, the legal authorisation of psychotropic medication on T2 and T3 certificates and the need for single room accommodation for patients on the ward.

The response we received from the service noted that audits would be undertaken at multidisciplinary review meetings (MDT) to ensure clear awareness of DNACPR certificates; that the service would ensure that occupational therapy staff and other trained staff would have access to the ward kitchen. All patients subject to T2 and T3 certificates would be reviewed at MDTs and that the redesign of mental health services and provision of single room accommodation would continually be considered.

On the day of this visit, we wanted to meet with patients, follow up on the previous recommendations, look at ongoing care and treatment, and hear about the plans for those patients currently awaiting discharge, as well as the overall throughput of patients moving in and out of the rehabilitation setting.

## Who we met with

We met with, and reviewed the care of seven patients who we met with in person. We also met with relative in person and spoke with one relative following the visit.

We spoke with the service manager, the deputy charge nurses, staff nurses, the occupational therapist and the consultant psychiatrist for the ward.

## Commission visitors

Justin McNicholl, social work officer

Douglas Seath, nursing officer

## What people told us and what we found

At the time of our visit, the ward was at capacity with 15 patients. The age range of the patients was from 46–78 years old and referrals came from other wards on the Leverndale site.

Many of the patients had complex needs, long-term physical health problems and had been in hospital for several years.

Some patients had been in the ward for a timescale that was expected with a period of rehabilitation, whilst others have been in the service for nearly 30 years, with no plans for discharge. We noted that there were two distinct groups of patients in the ward. There were patients boarding in Ward 2 due to bed pressures on the acute wards across the Leverndale site and there were patients who were there for a longer-term admission.

There were three patients who were boarding on the day of our visit with twelve patients who were longer-term admissions. There were particular challenges in providing care for such a diverse group of patients and in meeting their very different needs. However, we heard from nursing staff that they felt supported and equipped to do so with the appropriate training and equipment available to deliver essential care.

### Care, treatment, support and participation

On the day of this announced visit, we had full access to meet with patients, relatives, and staff. The ward has input from one locum consultant psychiatrist, occupational therapy (OT), a part-time pharmacist and a patient activities coordinator. Input from other professionals included dietetics, physiotherapists, speech and language therapy, physiotherapy and podiatry was arranged on a referral basis. We were told that the ward has had difficulties recruiting a permanent consultant psychiatrist; short-term locum psychiatrists have been working on the ward to ensure safe oversight of patients care. It was positive to hear that the recruitment and retention of nursing staff for the ward tended not to be challenging. Despite this, there remained the need to use agency staff on occasion to ensure adequate cover was available for each shift. We were advised that there were plans to have three deputy charge nurse posts to ensure cover for the ward in the coming months.

The patients and relatives we spoke to did not raise any specific concerns about the ward and spoke very positively about the care and treatment provided by the nursing staff, the psychiatrist, and the allied health professionals. Staff that we spoke with knew the patient group well and were able to answer all questions with clear context for all matters raised. One patient commented “they are good people”, while another patient told us, “the staff are brilliant, they are always kind and sociable”. A relative stated, “the staff are great, they are always helpful, that is important as it is not an easy job.”

We noted there is a diverse group of patients in the ward. Many of the patients’ admissions have lasted for decades and due to the nature of their mental illness there are challenges for staff to motivate and engage patients. Despite this we observed a variety of patients being supported to participate in activities of daily living, therapeutic, social, and recreational activities. This included the use of the therapeutic kitchen that was noted as not being fully utilised during our last visit. During this visit we saw that the occupational therapist had coordinated a weekly breakfast session for those patients who were able to participate.

We heard positive feedback from patients regarding their experience of the food provided. This included each patient describing their preference of food choices being met as well as hearing from patients with specific cultural diets that these were being respected.

Many of the patients had physical health issues and mobility problems. We observed that various patients had access to the appropriate equipment and footwear to ensure their safe movement throughout the ward. All patients had annual health checks and we saw evidence of this in the records.

## Care plans

When we last visited the service, we found examples of detailed and person-centred care plans that addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. On this occasion we found care plans that evidenced were possible, patient involvement. However, there was notable inconsistencies in how frequently these care plans were updated. Some of the care plans were over two years old. We discovered that reviews of care plans were lacking in consistency with different methods being used by staff to review these either monthly or via the multi-disciplinary team (MDT) process. We believe there is work to be undertaken by all members of the ward to improve the consistency of care plans and how these are reviewed. We discussed this with the deputy charges nurses on the day and the service manager.

There was a clear awareness of reviews happening but not being consistently reflected in the paperwork. We were aware that in the service as a whole, that care plans and reviews were being worked on, with a new style being adapted. We suggested using the Commission guidance on our website to help in the process.

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/node/1203

**Recommendation 1:**
Managers should regularly audit care plans to ensure these are current, that care plan reviews are taking place on a consistent basis, that they are person-centred and include all the individual's needs in care plan reviews.

We found the detailed daily notes contained in patient's records. We did not always see clear evidence of one-to-one discussions between patients and their named nurse; this appeared to relate to how unwell some of the patients on the ward were. We noted that further work needed to be undertaken to improve the recording in patients' files of one-to-one discussions, and we hope to see this at our next visit.

## Multidisciplinary team (MDT)

The ward has multi-disciplinary team (MDT) meetings. These include psychiatry, nursing, pharmacy, occupational therapy and other professions as and when required. The meetings were held weekly and each patient was discussed and reviewed a minimum of once every four weeks, but more frequently if required. The MDT's paperwork that we reviewed did not always demonstrate clear signposting of the patients' needs and the goals required for discharge. We

advised that the MDT process should be clear about the type of resources that were required to aid all patients with their move into the community, especially those who have been on the ward for many years.

Some of the patients that we spoke to reported that they were kept well informed by the MDT. Those patients who were boarding from other wards advised that they had regular contact with their primary psychiatrist. They did not report any disadvantage on receiving care or oversight by a separate MDT.

### Care records

Information on patient records was held mainly on EMIS, the electronic health record management system used by NHS Greater Glasgow and Clyde (NHS GGC). Additional documents continued to be held in paper files, including nursing care plans. There is a long-term plan in NHSGCC for all patients' records to be held on EMIS but there is no exact date confirmed for the transition to a paperless system. We found patients' records easy to navigate.

Some patients in Ward 2 were subject to the Care Programme Approach (CPA), a multi-disciplinary care management process. This approach was coordinated by a member of staff who ensured that these take place routinely. There was evidence that patients, relatives and advocacy staff participated in these meetings, as well as social workers and mental health officers (MHOs). We found some copies of the minute of CPA meetings but we could not locate minutes for all of these meetings.

**Recommendation 2:**
Managers should ensure that the minutes for all patients subject to the Care Programme Approach are recorded on file.

## Use of mental health and incapacity legislation

On the day of our visit, seven of the fifteen patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The relevant detention paperwork was readily available for all patients. Due to their memory impairments, some of the patients we met with during our visit did not have an understanding of their detained status and the fact that they were subject to detention under the Mental Health Act.

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. We found that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were recorded correctly with the relevant forms in place. We found no issues regarding the required mental health legal paperwork.

Some patients on the ward were subject to Part 4 of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). In relation to the patients' welfare benefits, this means that the NHS has applied for the Department of Work and Pensions (DWP) appointeeship role to manage patients' welfare benefits. We were able to find a clear recording of how the patient's finances were reviewed on a six-monthly basis, to ensure that these were monitored and administered safely. We heard no concerns from patients in relation to how this was being managed by the hospital.

Some patients in Ward 2 had established diagnoses of both mental and physical health conditions. For those patients assessed as lacking capacity, a section 47 certificate under Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') is required to authorise their medical treatment. During our visit, we found that s47 certificates and treatment plans were issued for all those patients who required this.

Some patients in Ward 2 were subject to welfare guardianship orders under the AWI Act. We did not always find copies of the relevant orders in those patient's records, or information with the associated interlocutor appointing either a private individual or the chief social work officer. Due to this gap in the information, it was not always clear to staff which powers were appointed to the guardian to make decisions for the patients.

**Recommendation 3:**
Managers and medical staff should ensure that where a patient has an appointed welfare guardian a copy of these orders is stored within the patient's records.

## Rights and restrictions

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Ward 2 had a locked door, commensurate with the level of risk identified with the patient group. No patients on Ward 2 were subject to specified person restrictions.

We found that risk assessments in each patient's records were detailed, thorough and comprehensive. These were also reviewed and updated regularly at MDT meetings.

When we are reviewing patients' records, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act and is written when a person has capacity to make decisions, and sets out the care and treatment they would like, or would not like, if they become ill again in future. Health boards have a responsibility for promoting advance statements.

We found no evidence of any advance statements for any patients in Ward 2. In speaking with staff, there was no apparent promotion of advance statements in the ward aside from a note taken during each MDT no whether one existed. The Mental Welfare Commission has produced advance statement guidance which can be found at:
advance_statement_guidance.pdf (mwcscot.org.uk)

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

**Recommendation 4:**
Managers should ensure that a programme of training is supplied to all staff in relation to advance statements which should be promoted in the ward and these discussions be clearly documented in the patient's clinical notes and care plan.

During our last visit we had concerns around the recording and oversight of patients on Ward 2 placed on DNACPR (do not attempt cardiopulmonary resuscitation) orders. We made a recommendation to improve this which included signposting to management of the Scottish Government revised policy on DNACPR in 2016 at:
http://www.gov.scot/Resource/0050/00504976.pdf.

Despite this, we continued to find gaps in the recording of these orders. The guidance makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded.

The DNACPR forms that we reviewed were not completed with evidence of discussion with the identified guardians. There was a lack of consultation with the chief social work officer, who had been appointed for some patients. We did find that all of the DNACPR orders had been reviewed in the requisite timeframe stated on the form, and were clearly displayed on the ward information board, as well as at the front of patient's records.

It is necessary for proxies to be involved in the patient's care, and to be aware that a decision not to give CPR has been made and documented on a DNACPR form. This not only ensures that CPR treatment in not erroneously withheld, but equally that inappropriate, contraindicated and/or unwanted attempts at CPR, which are of no benefit and may cause significant distress to patients and families, is not attempted.

**Recommendation 5:**
Managers should ensure an audit of all DNACPR forms is urgently carried out to ensure that, where relevant, all DNACPR decisions are reviewed and consider implementing a system to ensure that all staff members are aware of the DNACPR status of every patient on the ward.

## Activity and occupation

Activities in rehabilitation wards are essential to ensure recovery planning that aids with patient re-integration into the community. We were pleased to hear from patients and from our observations that occupational therapy (OT) and activities coordinator provision for the ward is valued. The activities coordinator is employed to work flexibility with patients during the day and evening to promote activities. This resource ensured that there was an offer of support and activities for all patients that promoted stimulation and social outlets. We heard from some patients that the range and level of activities was good. Some patients in the ward access the recreational therapy (RT) department on the Leverndale site. This input was well regarded by both patients and staff. We observed that some patients were reluctant to participate in some activities; despite this we saw successful efforts to engage them.

## The physical environment

The physical environment of the ward remains largely unchanged since our last visit. Most of the ward space was bright, spacious, clean, in good decorative order and had a lot of natural light. We did discover a significant hole in the plasterboard of one of the walls in the male

dormitory, which was reported to management for repair. There are two sitting rooms, both rooms are comfortable and appeared well furnished.

There were six single rooms with shower and toilet facilities nearby. The male four-bedded dormitory area was found to be relatively spacious. The female five-bedded dormitory felt cramped with a limited amount of space for patients to move around when curtains were drawn around beds. For those female patients sharing the dormitory this level of noise and cramped environment did not appear pleasant. We did observe that patients had personalised their sleeping areas and bedrooms, which helped to make them feel more homely.

As noted in our last report, many wards across NHSGGC have been refurbished to provide patients with individual rooms and we would strongly encourage managers to consider the same here to ensure privacy and to protect dignity, especially given the fact that many of this particular group of patients can be in hospital for fairly lengthy periods of time.

There was a garden area to the front of the ward and a well maintained medium-sized garden to the rear, which was well presented on the day of our visit. We were told that this area is regularly used by the patients and we were told that many of the patients during the summer months enjoy eating food whilst sitting in the garden. These areas appeared peaceful and therapeutic for those seeking a quiet break from the ward.

**Recommendation 6:**
Managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.

## Summary of recommendations

**Recommendation 1:**
Managers should regularly audit care plans to ensure these are current, that care plan reviews are taking place on a consistent basis, that they are person-centred and include all the individual's needs in care plan reviews.

**Recommendation 2:**
Managers should ensure that the minutes for all patients subject to the Care Programme Approach are recorded on file.

**Recommendation 3:**
Managers and medical staff should ensure that where a patient has an appointed welfare guardian a copy of these orders is stored within the patient's records.

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**Recommendation 6:**
Managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.

## Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

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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