Mental Welfare Commission for Scotland

Report on unannounced visit to: Leverndale Hospital, IPCU, 510 Crookston Rd, Glasgow G53 7TU

Date of visit: 18 July 2023

Where we visited

The Intensive Psychiatric Care Unit (IPCU) at Leverndale Hospital is a 12-bedded unit for patients (aged 18-65 years) requiring intensive treatment and intervention. Patients are generally admitted from the South Glasgow area. On the day of our visit, there were no vacant beds.

The ward is a mixed-sex facility, split as maximum of three female (single rooms) beds and 9–12 twelve male beds, in a mix of single rooms and small dormitories. On the day of our visit, the ward was over the occupancy limit with 13 patients in the ward, with 10 male patients and three female patients. The additional male patient was being nursed in the low stimulus room with a clear plan in place for the occupancy to return to its 12-bedded capacity in the forthcoming 24 hours.

We last visited this service on 18 January 2023; we made eight recommendations regarding the need to address the use of agency staff, prescribing of 'as required' medications in line with NHS Great Glasgow and Clyde policy (NHSGGC) and best practice guidelines to ensure dosages, routes of administration and maximum daily dose are clear, the need to ensure drug allergies were clearly recorded, that there was clear care plan auditing to ensure they were person-centred and that advocacy was easily accessible. We also recommended that there was staff training required on the promotion of advance statements and that reviews of enhanced levels of observation took place and were recorded in line with improving observation practice guidelines. Lastly, we made a recommendation that a programme of work was undertaken to ensure that the IPCU provided a conducive setting for patients.

The response we received from the service was that managers were addressing the recommendations and had an action plan in place, working towards completion.

On the day of this unannounced visit, we wanted to check the progress of actions around recommendations made in two previous visits in 2022 (announced) and 2023 (unannounced). We also wanted to check progress of the recommendations made and the NHSGGC Significant Adverse Event Review (SAER) process which had highlighted concerns regarding the deaths of two patients in the IPCU over the last three years.

We wanted to meet with as many patients on the ward as possible to hear about their experiences and any concerns they had about their care and treatment.

Who we met with

We met with and reviewed the care of eight patients. We spoke with the operational nurse manager, the deputy charge nurse, and nursing staff throughout the day.

Commission visitors

Justin McNicholl, social work officer

Sheena Jones, consultant psychiatrist

Mike Diamond, social work officer

Douglas Seath, nursing officer

What people told us and what we found

Care, treatment, support and participation

As this visit was unannounced, patients and staff were not prepared to meet with the visiting officers. Despite this, we were given full access to the ward, and to meet with patients and staff.

During our meetings with individual patients, we discussed a range of topics that included contact with staff, patients' participation in their care and treatment, activities available to them and views about the environment. We were also keen to hear from any patients who had previously been admitted to the IPCU, and what their current experience was like compared to a previous admission.

We were told by patients that staff were "respectful", "polite" and "helpful". We heard that they responded well when patients were distressed and required support. Many patients had a good knowledge of the activities available. However, not all patients were keen to engage in the activities but found it positive to have these social outlets available. Patients told us they found the environment "not ideal", "noisy" and "in need of improvements". We were aware that there has been no work carried out to the ward since our visit in January 2023. Patients advised that there tended to be a consistency in staffing levels. The patients praised the nursing staff and student nurses, and told us that they found them to be "approachable".

During our last visit there were concerns noted around the levels of agency staff; the recruitment and retention of nursing staff was a concern. During this visit, there was a marked improvement on the reliance on agency staff, with no agency staff present during the visit. We heard that consistent bank staff were deployed to the ward to ensure safe levels of patient care are delivered. The regular use of bank staff as opposed to agency staff appears to have worked well on the ward and has improved patient experiences. It was noted that the permanent members of the ward know their patients well, had good links with the wider multidisciplinary team and were able to support carers and relatives.

On the day of this visit there were four patients admitted to the IPCU who were classed as a delay discharges due to ongoing bed capacity issues in Leverndale Hospital. We heard from staff and patients that having a swift transition from the IPCU to the adult acute wards was important and without it, there was a risk of patients deteriorating, particularly in relation to their motivation and preparedness for eventual discharge. We heard from staff that having bed managers as part of the service has helped to avoid unnecessary delays for most patients. When patients were deemed fit for discharge, we heard that passes to visit a patient's home were not an issue when staffing resources were available. Two patients told us they had felt isolated at times and while staff were making every effort to ensure their admission to hospital was comfortable, patients would have preferred to be home as soon as possible.

When we last visited the ward it was described as a "pressure cooker" by members of staff. During this visit patients spoke positively about the atmosphere being "calm" compared to their previous admissions. Staff advised that they felt "supported" by their colleagues which helped to make the ward a "good place to work".

The ward has input from one consultant psychiatrist, one doctor with a specific remit for the ward and one junior doctor. There were six members of staff on shift during the visit with two of these being trained nursing staff. We heard from nursing staff that access to medical staff remains unchanged since the last visit and that there is a high ratio of staff to patients; this remains important in an IPCU ward where there are increased levels of clinical risk and patients' needs are high. There was one patient on enhanced observations at the time of our visit which was a significant reduction compared to our last visit. We were able to access their observation sheets during our visit; these were up-to-date and consistent with recording standards.

Since our last visit, there have been no further adverse events reported to the Commission. During our last visit we had concerns regarding the recording of drug allergies, and we further discovered that the frequency of the use of as required medication was not specified for certain patients. Positively, during this visit we found both aspects of treatment clearly recorded and noted in patients' records.

When we last visited the service, we found evidence of poor examples of person-centred care plans that lacked a therapeutic or recovery focus, with clear goals or outcomes for patients. On this occasion, we found a significant improvement in care plans with detailed person-centred records. This ranged from 72-hour care plans to standard care plans and review care plans. All of the records that we reviewed, except one, evidenced patient involvement. We could see clear evidence on what was being addressed via the multidisciplinary team meeting process and in one-to-one sessions, with patients' named nurses. It was good to see this level of improvement in the ward and we hope to see this maintained when we next visit the ward.

Multidisciplinary team (MDT)

The IPCU has a broad range of staff providing input for each patient. These include nursing staff, consultant psychiatrists, occupational therapists, psychologists and activity co-ordinators. For patients who required additional support from allied health professionals, referrals were made to specific services. Each member of the MDT provided care and treatment specific to their expertise and where required, provided weekly feedback at the meeting. We found MDT meeting notes were detailed with clear progress or future plans noted. This also included the views of the patients and their families should they have wished to attend.

We found patients' records easy to navigate, and there was a clear focus upon individual patients' mental and physical well-being. CRAFT risk assessments that we reviewed were detailed, regularly reviewed, and we saw individual risk management plans included in the patients' records.

Care records

Patients' records are held mainly on EMIS, the electronic health record management system used by NHSGGC. Additional documents continue to be collated 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 no exact date has been confirmed for this to occur. We look forward to hearing how this will be implemented for the ward and how staff and patients adjust to this transition in due course.

We found the majority of records on the electronic and paper systems up to date.

Patients generally described feeling involved in their care and treatment, their expectations for their admission to hospital were clearly communicated to staff and an account recorded in their care records. We found evidence of "Getting to know me" forms that help visitors and staff understand a patient's journey and their expectations for the future.

We observed that the ward had a number of laptops available for nursing staff to use, in order to update records in 'real time'.

Use of mental health and incapacity legislation

On the day of our visit, all 13 patients in the IPCU were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 ('CPSA'); the majority of the orders in place were under the Mental Health Act, and we found the appropriate detention paperwork was readily available.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were found be in place. One patient was found to be subject to a T4 where it was necessary, as a matter of urgency, for medical treatment to be given to the patient.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Rights and restrictions

The IPCU operated a locked door policy commensurate with the levels of vulnerability and risk of the patient group. There were individual detailed risk assessments in place for patients which set out the arrangements for time off the ward and the support required to facilitate this safely.

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. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place. We were pleased to find staff were knowledgeable about specified person legislation and the storage of paperwork relating to this legislation, which was easily located in care records.

We looked at advance statement on this visit; these are written by someone who has been mentally unwell, and the advance statement sets out the care and treatment they would like, or would not like, if they become ill again in future. We found an advance statement for a patient in the IPCU. This was an improvement compared to our last visit. Speaking with staff and managers, we heard that there was a plan in place to address the ongoing promotion of advance statements in the ward.

We noted that some patients had no allocated mental health officers appointed. We will follow this up with Glasgow Health and Social Care Partnership, who need to ensure that all patients are supported appropriately whilst subject to the Acts.

Recommendation 1:
Managers should ensure that mental health officers are allocated for all patients whilst subject to the Acts.

We heard from a number of patients that they had not been informed of the role of advocacy services; as result they were not aware of their rights. The lack of advocacy input is a matter that was highlighted during our visit in January 2023 and needs to be addressed by managers promptly, so that patients have access to a service that supports them in understanding how their rights are protected and reviewed throughout their journey in the service.

Recommendation 2:
Managers should ensure that access to advocacy services is prioritised for all patients.

We were also pleased to hear from staff that there has been a significant decrease in the use of the de-escalation room and incidents of violence. Staff report that the success in the reduction has been due to the use of verbal de-escalation techniques.

Activity and occupation

We were pleased to hear of the ongoing positive work of the therapeutic activity nurse (TAN) employed to work flexibility with patients out with the routine 9am-5pm timetable. This role has ensured that there was an opportunity to offer activities to all patients. During our visit we were able to observe a full list of daily activities in the ward. Patients spoke very positively of the TAN; “they have helped to organise lots of activities including walks, pool, movie nights, bingo and art sessions”. We were able to find clear evidence of activity participation by patients in their notes. We were advised of the ongoing input supplied to the ward by occupational therapy staff that included access to a smoothie group, which patients enjoyed. The patient group work with the occupational therapy staff also provided a positive social outlet as well as health food choices. Some patients told us they were awaiting assessments to undertake a variety of recreational and therapeutic activities that included access to the gym. The delay for patients in accessing the gym was due to awaiting risk assessments.

We heard a number of comments from patients regarding the lack of access to an iPad on the ward. The previous iPad had been damaged by a patient and had not yet been replaced by the management. We suggest this matter is addressed promptly as it remains an important outlet for patients in a restricted environment.

The physical environment

The physical environment of the ward remains largely unchanged since our last visit. The ward remains stark, with an aging environment where general wear and tear was apparent throughout all areas of the ward. The basic decor of the ward does not provide for a positive experience for patients, with some requiring to sleep in dorms with fellow patients. The lack of en-suite facilities continued to be raised by those patients that we spoke with. The noise levels and the ageing facilities were far from ideal for maximising patient care. We heard from

managers that there were plans to change the physical layout of the ward in the foreseeable future but there was no specific timescale as to when this will occur.

Recommendation 3:
Managers should develop a programme of works to update the current environment to ensure that it provides a conducive setting for patients.

Any other comments

Since we last visited the ward there have been steps taken by the management to address our previous recommendations. This formed an action plan and a separate work plan following the two Significant Adverse Event Reviews (SAER) that highlighted concerns regarding the deaths of two patients in the IPCU over the last three years. We explored these plans and the impact upon patients' care. We found clear evidence that the plans in place had helped to end the use of agency staff. We found training had been undertaken by pharmacy staff to ensure clear and consistent recording regarding patients' drug allergies, as well as the prescription of "as required" medication with specific dosages to ensure safe prescribing.

We found that actions have been taken to address the adherence to safe observations levels in line with the continuous intervention policy. This included the delivery of training for all staff that focused on timely and regular reviews, along with focused discussions at staff handovers meetings about safe observations. This has satisfied the Commission that these actions have been put in place to improve practice and to address the concerns found in the SAER's. It was positive to note the improvements and we hope this will continue to improve patients' care on a consistent basis and reduce the likelihood of further adverse events. We will review these matters during our next visit to the ward.

We also noted that this is the first occasion in last two years where there have been admissions of female patients to the IPCU, which appears to be working well in the IPCU.

Summary of recommendations

Recommendation 1:
Managers should ensure that mental health officers are allocated for all patients whilst subject to the Acts.

Recommendation 2:
Managers should ensure that access to advocacy services is prioritised for all patients.

Recommendation 3:
Managers should develop a programme of works to update the current environment to ensure that it provides a conducive setting for patients.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk