Mental Welfare Commission for Scotland

Report on announced visit to:

Leverndale Hospital, Ward 3A and Ward 3B, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 28 November 2023

Where we visited

Ward 3A is an adult acute mental health admission ward that covers the geographical area of South Glasgow including Barrhead, Pollock and Crookston. The ward has 24 beds and is divided into two inpatient areas that have single and dormitory bedrooms.

Ward 3B is also an adult acute mental health admission ward and is managed offsite by Dykebar Hospital, and covers the Renfrewshire area. The ward has 24 beds and is divided into two inpatient areas that have single rooms and dormitory bedrooms. Ward 3B has responsibility for ESTEEM, a mental health service for individuals aged between 16 and 35 years old, who are experiencing a first episode of psychosis.

At our last visit to Ward 3A was in May 2022, and we made three recommendations, and when we previously visited Ward 3B in November 2022, we made two recommendations. Recommendations included care plan auditing, supporting visiting arrangements and activity provision.

On the day of our visit, we wanted to follow up on recommendations and any progress made. We also wanted to speak with individuals and staff, and listen to their views on care, treatment, and the environment.

Who we met with

We met with and reviewed the care of 18 individuals, and we reviewed the care notes of one further individual. We also spoke with two relatives on the day of our visit.

We met with allied health professionals, senior charge nurses (SCN), charge nurses (CN) and staff nurses.

Commission visitors

Gemma Maguire, social work officer

Kathleen Taylor, engagement and participation officer

Mary Hattie, nursing officer

Douglas Seath, nursing officer

What people told us and what we found

Feedback provided by individuals from both wards was positive, with staff described as "brilliant", "always willing to help" and "they are so lovely". Staff we spoke with had a good understanding of individual needs and showed a commitment to supporting those they cared for.

Individuals from both wards reported to us that they enjoyed a range of recreational therapies such as on-site gym sessions, creative writing, art therapy, relaxation, gardening, and walking groups.

Care, treatment, support and participation

Relatives we spoke with on the day of the visit reported that staff listened to their views, and that they felt included in decision-making regarding their loved ones. We were pleased to see that both wards displayed information to support carers, including access to local support groups.

The Commission have published a good practice guide on carers and confidentiality. The guide is to help carers and families understand consent, confidentiality, and sharing of information. It will also guide health and social care practitioners and can be found at: https://www.mwcscot.org.uk/node/415

Both wards are involved with 'patient conversations' which is delivered by individuals with lived experience, promoting values of empowerment and recovery. We were pleased to learn that Ward 3A have recently started community meetings to encourage participation. Across both wards, individuals we spoke with felt they could express views and that they were involved in their care.

Care planning

On our last visit to each ward, we made recommendations relating to care plan auditing, reviews and ensuring person-centred approaches were consistently carried out. We were pleased to find that care plans were accessible with person-centred goals that were regularly reviewed. Several individuals we spoke with had a detailed understanding of the goals on their care plans, reporting regular one-to-one time with nursing staff, and had signed copies of their care plans.

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

Care and treatment experienced by individuals

We were advised individuals may be admitted to Ward 3A for care and treatment in relation to eating disorder. We heard staff described as "lovely" however, there was a sense that there was a lack of understanding regarding the needs of eating disordered individuals; an example of this that we heard about was when individuals are questioned around already agreed diet plans. We discussed these issues on the day of the visit and were advised the ward has access to the in-reach specialist eating disorder services, as well dietician and psychology input.

Recent staffing changes were discussed, and we were advised that previously trained staff, with experience of supporting individuals with eating disorder, had left the service. We were informed that training in relation to eating disorders is available and will be progressed with the current staff group. We look forward to seeing progress in this area at future visits.

The Commission has published a themed visit report looking at eating disorder services across Scotland. People who provide care, treatment, and support for people with eating disorders can read this report and reflect on their current practices. The report can be found at EatingDisorders_ThemedVisitReport_03Sept2020_0.pdf (mwcscot.org.uk)

Individuals we spoke with on Ward 3B reported that whilst most staff are "excellent", some reported "staff are changing all the time". We were advised by one individual that their named nurse was "brilliant", however some staff "change the rules" and "I have to keep telling them about my care plan". All individuals we spoke with felt able to raise concerns with named nurses and/or the CN in the ward. We discussed the issues raised regarding perceived staff behaviours with Ward 3B managers on the day of our visit. We were advised that several experienced staff have moved on, however recruitment work undertaken by the service has helped to fill all vacancies on Ward 3B.

We were also informed that agency staff are no longer used by the service. Instead, bank staff are used which provides more consistency when supporting patient safety during increased use of observations. We were told that training will be rolled out with nurses, bank staff, and health care assistants, to ensure trauma-informed approaches are understood by all staff. We look forward to hearing progress on future visits.

Issues raised by individuals regarding perceived staff behaviours are being followed up separately.

Multidisciplinary team (MDT)

MDT meetings continue to be held weekly in Ward 3A and Ward 3B, with consultants visiting the wards and meeting individuals throughout the week. We were pleased to hear individuals felt involved in meetings, with views consistently recorded. Ward 3A has six inpatient consultants who also cover outpatient services at Florence Street and Rossdale mental health resource centres. Ward 3B has three inpatient consultants, one of whom is responsible for ESTEEM, a mental health service for people aged 16-35 years old, who experience a first episode of psychosis and require in-patient care. At the time of our visit four individuals were admitted under this service.

Ward 3A and Ward 3B MDT meetings also included pharmacy, dietician, and occupational therapy. We were pleased to hear that family members were regularly invited, with their views recorded in meetings. We were also advised that both wards have access to psychology services.

Hospital discharge

On the day of our visit no one was reported to be delayed in their discharge from hospital. We spoke with one individual who expressed concern regarding a lack of progress in their discharge after being admitted to Ward 3B for three years. The individual had raised their concerns with their MDT, as well as exercising right of appeal under the Mental Health Act. We reviewed the individual's notes and found clear MDT discussion involving social work, demonstrating various attempts to source appropriate care and support to meet the individual's complex needs. Issues raised by individuals in relation to their discharge is also being followed up separately.

In discussion with the CN, we were advised that Ward 3B have a full-time community mental health social worker attached to the ward, which has helped to progress assessments for individuals. On Ward 3A we were pleased to learn that the role of the integrated discharge coordinator liaises with HSCPs, which has in turn provided earlier access to social work assessment and services for many individuals.

Managers of both services advised us that where an individual is delayed in their discharge from hospital, there are escalation processes in place, with regular auditing and scrutiny involving senior managers across the HSCPs. For those we spoke with and/or reviewed, there was evidence that the current level of care and treatment was required, and discharge planning was progressing where appropriate.

Risk assessment

During our visit we noted that individuals on Ward 3A had risk assessments consistently reviewed and updated, which we considered to be a best practice approach. The risk assessments we reviewed on Ward 3B showed that review and updates were taking place, but this was not consistent. We were advised, in line with service policy, that risk assessment documents are only updated when there is a change. We advised Ward 3B managers that clear recording of risk assessment discussions that take place in the MDT meeting, even where there is no change, would be benefit from noting that a review had taken place.

Recommendation 1:
Managers responsible for Ward 3B should ensure that risk assessment documentation is reviewed regularly and updated accordingly.

Use of Mental Health and Incapacity legislation

On the day we visited 14 individuals on Ward 3A, and 18 individuals on Ward 3B, were subject to The Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The legal status of individuals subject to the Mental Health Act was clear and accessible on electronic recording systems across Ward 3A and Ward 3B.

Part 16 of the Mental Health Act sets out conditions under which treatment may be given to individuals subject to compulsory measures, who are either capable or incapable of consenting to specific treatments, including medications. To authorise treatment, T2 certificates should be used for individuals who can consent, and for those who cannot consent, T3 certificates should be used. We reviewed all T2 and T3 certificates and found these were correct and in place.

On the day we visited, one individual reviewed in Ward 3A was subject to a welfare guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) . There was no information about the guardianship or copies of the powers in the file, and staff were unaware the order was in place. Under the AWI Act, a section 47 certificate and treatment plan should be completed by a doctor where an adult is assessed to lack capacity regarding medical decisions. The individual subject to guardianship in Ward 3A had been assessed to lack capacity relating to medical decisions, however no s47 certificate had been issued to authorise medical treatment.

Issues in respect of the AWI Act were discussed with staff and managers for Ward 3A on the day of our visit. We were advised copies of the guardianship powers and requirement for s47 certificate would be followed up.

Recommendation 2:
Managers responsible for Ward 3A should ensure copies of welfare guardianship powers are available for relevant staff and these powers are clearly documented in notes.

Recommendation 3:
Managers responsible for Ward 3A should ensure adults assessed as lacking capacity regarding medical decisions have section 47 certificates and treatment plans in place to authorise medical treatment.

The Commission is working in partnership with NHS Education for Scotland to develop learning resources for the workforce to support and promote people's rights in the application of AWIA. Learning resources can be accessed here:

Adults with Incapacity Act | Mental Welfare Commission for Scotland (mwcscot.org.uk).

Rights and restrictions

We were pleased to note that individuals subject to detention under the Mental Health Act had been advised of their rights verbally and in writing, and they informed us that they understood the specifics of their detention under the Act; we also heard that they were either accessing, or knew how to access advocacy services.

During our last visit to Ward 3A, Covid-19 visiting restrictions were in operation, and we recommended that visiting procedures should be updated in line with Scottish Government guidelines. We were pleased to find that visiting was now only restricted to protect mealtimes. Those that we met with felt contact with their family was supported and were happy with their relatives involvement in their care.

Sections 281 to 286 of the Mental Health Act relate to specified person restrictions, which are the appropriate legal safeguard when placing restrictions on an individual who is detained in hospital. Making someone a specified person should be the least restrictive option and where not doing so would place them, or others, at significant risk of harm. The individual subject to such measures should receive notification in writing about restrictions applied, timescales involved and their right of appeal, unless doing so would be detrimental to their mental health.

During our visit, two individuals on Ward 3A, and one individual on Ward 3B, were found to be specified. For the individuals on Ward 3A, documentation relating to this, including reasoned opinion, was appropriately in place. The individual on Ward 3B informed us that they had received verbal notification of the restrictions; however nothing was provided to them in writing. Upon review of documentation, whilst there was a reasoned opinion available, there was no record of written notification being provided to the individual. We discussed this issue with staff on the day of the visit and were advised this would be follow up.

Recommendation 4:
When someone is made a specified person, psychiatrists, and managers on Ward 3B should ensure, where appropriate, they are provided with the required written notification about the restrictions applied, timescales involved and right of appeal.

The Commission has published a good practice guide in relation to specified person which nursing and medical staff may find helpful when considering restrictions: https://www.mwcscot.org.uk/node/418

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals 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

Individuals told us they enjoyed a range of activities on both wards, and at the onsite recreational therapy (RT) centre. Information on each ward's activities was on display with a range to choose from.

The RT centre offers music and art groups, creative writing, gardening, football, and walking groups Monday to Friday. Following our last visit, we recommended that individuals on Ward 3B were given equitable access to the RT centre. We were pleased to find that this has been addressed and individuals from Ward 3B can access the RT centre in line with other Leverndale Hospital wards.

Individuals on Ward 3B benefit from ward-based activities, supported by the occupational therapy team. There is access to a therapy room for relaxation, art and music activities as well as use of gym equipment. Ward 3B also has access to a therapy kitchen which supports the development of cooking skills and functional assessments in preparation for discharge.

Ward 3A activities are supported by the therapeutic activity nurse (TAN), who provides one-to-one discussions, bingo, karaoke, and walks. Several individuals that we spoke with told us how much they enjoyed this service. The TAN provides a service five days out of seven, ensuring some weekend activities are available to individuals. This is beneficial given availability of activities is reduced at weekends when the RT centre is closed.

The physical environment

Several individuals and staff that we spoke with during the visit advised us that the general physical environment on both wards is 'tired looking' and 'could be doing with an upgrade'.

Staff and individuals have made attempts to visually improve the environments, by displaying artwork and posters throughout the wards.

Whilst both wards each have access to two single bedrooms, the majority of individuals are accommodated in shared dormitories. We heard from some individuals that they enjoy the company that a dormitory room offers them, whilst others told us they would prefer the privacy of having their own bedroom. One individual told us they were physically assaulted by another patient in the dormitory and whilst they praised staff for their support in relation to this, they were of the view that this happened because of the shared dormitory environment. The incident was responded to appropriately, and dealt with in line with local procedures, including incident review and updated risk assessments.

The environment remains an ongoing challenge for staff to prioritise space based on individual need and risk assessment. As discussed in our previous visits, issues can only be changed by reconstruction and redesign of the environment.

Summary of recommendations

Recommendation 1:
Managers responsible for Ward 3B should ensure that risk assessment documentation is reviewed regularly and updated accordingly.

Recommendation 2:
Managers responsible for Ward 3A should ensure copies of welfare guardianship powers are available for relevant staff and these powers are clearly documented in notes.

Recommendation 3:
Managers responsible for Ward 3A should ensure adults assessed as lacking capacity regarding medical decisions have section 47 certificates and treatment plans in place to authorise medical treatment.

Recommendation 4:
When someone is made a specified person, psychiatrists, and managers on Ward 3B should ensure, where appropriate, they are provided with the required written notification about the restrictions applied, timescales involved and right of appeal.

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.

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