Mental Welfare Commission for Scotland

Report on announced visit to:
Leverndale Hospital, Ward 4A and Ward 4B, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 1 November 2023

Where we visited

Ward 4A is an adult acute mental health admission ward and covers the geographical area of Eastwood, Barrhead (East Renfrewshire) and Castlemilk (Glasgow City). The ward has 24 beds and is divided into two in-patient areas which have single rooms with en-suite facilities.

Ward 4B is also an adult acute mental health admission ward and covers the geographical area of Govan and Ibrox (Glasgow City) and Cambuslang and Rutherglen (South Lanarkshire). The ward has 24 beds and is divided into two inpatient areas which have single rooms with en-suite facilities. Ward 4B has responsibility for ESTEEM, a mental health service for individuals aged between 16 and 35 years old, who appear to be experiencing a first episode of psychosis.

On our last visit in May 2022, we made nine recommendations for Ward 4A and eight recommendations for Ward 4B. Recommendations included authorisation for medication, support for religious and cultural needs, accommodating dietary requirements, care plan auditing, access to risk assessment documents, supporting visiting arrangements and activity provision.

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

Who we met with

We met with and reviewed the care of 11 patients, and we reviewed the care notes of a further five individuals.

We met with consultant psychiatrists, allied health professionals (AHP), senior charge nurses (SCN), charge nurses (CNs), staff nurses and nursing assistants.

Commission visitors

Gemma Maguire, social work officer

Graham Morgan, engagement and participation officer

Mary Leroy, nursing officer

Yvonne Bennet, social work officer

Mary Hattie, nursing officer

What people told us and what we found

Feedback provided by those that we spoke with was very positive; they described staff as "really understanding" and told us that "they make me feel safe". Staff we spoke with had a good knowledge of those they cared for and we observed warm and caring interactions in a calm environment throughout the day.

Several individuals from both wards told us of the high standard of care compared to their experiences in different services. One individual said it was "the best of all the wards".

We heard about how people enjoyed a range of recreational therapies, such as onsite physiotherapy, gym sessions, music and art groups, gardening, football, and walking groups.

Care, treatment, support and participation

When we last visited, there were positive reports from individuals regarding the care they received from staff. We are pleased to hear this has continued and that most individuals feel listened to.

We previously recommended support for individual cultural and religious beliefs, as well as dietary requirements. Since this time the service has updated care plans and admission assessments to include individual religious and dietary needs. We were pleased to learn that a chaplain was available, offering community contact to support various religious needs. Those we spoke to were aware as to how they could access this service and information was available throughout the wards. We heard of family members having 24-hour access to bring specific food items based on individual need, and ward funds being used to meet dietary requirements when someone was admitted out of hours. We were also advised that the catering department has undertaken audits of menus that individuals contribute to. One individual reported the food tasted "home cooked, and you have a good choice" but felt the menu rotation could be repetitive if an admission was longer than a few months.

We were pleased to hear that a carers support group was available for family and carer participation.

We recognise that peer support groups can promote individual participation and recovery. The benefits of peer support groups were discussed with SCN and managers on the day of the visit, and we look forward to hearing of any future developments.

Care planning

At our last visit, we made recommendations in relation to care plan audits that ensured person-centred approaches were consistently carried out. During this visit we were advised that the service has since implemented 'what matters to you' care plans, focusing on individual need. We were pleased to note that care plans were person-centred with individualised goals. Several of those that we spoke with gave us a detailed understanding of their goals, reporting regular one-to-one time with their named nurses and they had received copies of care plans. One individual that we spoke with requested a copy of their care plan, which was passed to SCN for follow up on the day. Another individual advised us that the support in their care plan "helped me to ask for help and to trust people again".

Accessing care plans was difficult on both wards given the current template is not accessible on the main electronic recording system, EMIS. We had some difficulty locating care plans, with some being stored in paper files and others that were saved electronically on a separate drive. On one occasion we discovered a paper copy of a care plan with out-of-date information. This was passed to SCN for follow up on the day. During our last visit we noted similar issues, and advised the SCN of our concerns that this could lead to information going missing.

We were previously advised of ongoing service discussions for all records to be stored on EMIS. On this visit we were given and update of the service wide plans that are in place for care plans to be accessed via EMIS, however there is no timescale for completion.

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 ensure all care plans are accessible and consistently stored.

Some individuals we spoke with had a diagnosis of autism. Most reported staff to be understanding and supportive of their needs. We heard from one individual that whilst staff "try to do what they can", the ward environment can be a difficult sensory experience and they often spend time alone in their room as a result. Having discussed this with SCN and managers on the day of the visit, we were advised training for autism is available to staff. Additionally, we were informed of an in-reach learning disability team who provide specialist autism services for individuals, including assessment of sensory needs, if required. The SCN agreed to follow this up.

Multidisciplinary team (MDT)
MDT meetings continue to be held weekly in Ward 4A and Ward 4B, with consultants visiting the wards and meeting patients throughout the week. We were pleased to hear individuals felt involved in meetings, with their views being consistently recorded. Ward 4A has four consultants and Ward 4B has five 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.

Ward 4A and Ward 4B MDT meetings also have input from pharmacy, psychology, physiotherapy and occupational therapy. We were pleased to hear that family members were regularly invited, with their views recorded in the record of the meeting.

During our last visit, we recommended that managers responsible for Ward 4A and Ward 4B should work with health and social care partnerships (HSCP) to ensure timely discharge for individuals. We were pleased to learn that the integrated discharge coordinator liaises with HSCPs, which has in turn provided earlier access to social work assessment and services for many individuals.

On the day we visited, Ward 4A had no one reported as delayed in their discharge from hospital. Ward 4B had two individuals who were considered delayed in their discharge. For

both these individuals there was evidence of wider HSCP involvement in the MDT, including social work. For another individual reviewed, who was not yet ready for discharge but required ongoing social work assessment, the involvement of social work was not recorded in their MDT notes. We were informed that communication and MDT attendance from some social workers can be inconsistent due to resource issues across HSCPs. We advised the SCNs that recording and auditing attendance, including nonattendance, at MDT meetings can help identify and escalate issues to prevent delay in hospital discharge. We look forward to hearing about the continued progress in communication with HSCPs at our next visit.

At our last visit we recommended that managers responsible for Ward 4A and Ward 4B should ensure risk assessment documents were accessible and updated in a timely manner. During this visit we noted several risk assessment documents had not been updated for some time. We were informed that risk assessment is reviewed in MDT meetings. We were further advised, in line with service policy, that risk assessment documents are only updated when there is a change. We advised managers that clear recordings of risk assessment discussions in the MDT meeting, even where there is no change, would be useful to demonstrate that review has taking place.

Recommendation 2:
Managers should ensure that risk assessment documentation is reviewed regularly and updated accordingly.

Use of Mental Health and Incapacity legislation

On the day of our visit, there were 16 individuals in Ward 4A, and 14 individuals in Ward 4B, who 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 the electronic recording systems for Ward 4A and Ward 4B.

During our last visit we recommended that managers responsible for Ward 4A ensure medication records are reviewed in relation to appropriately authorising medical treatment under the Mental Health Act, and Adults with Incapacity (Scotland) Act 2000 (the AWI Act).

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 were advised the service has introduced an action plan to audit T2 and T3 certificates. We reviewed all T2 and T3 certificates and found that despite the introduction of the audit, both wards had some certificates which did not include all the medications prescribed to individuals. This was fed back to SCNs on the day of our visit who agreed to follow this up with psychiatrists.

Recommendation 3:
Managers should ensure the review and audit of medication records for individuals requiring T2 and T3 certificates to authorise their treatment under the Mental Health Act is carried out and findings acted upon in a timely way.

Under the AWI Act, a section 47 certificate should be completed by a doctor where an adult is assessed to lack capacity regarding medical decisions. Where individuals had been assessed regarding this, we found they were appropriately subject to a section 47 certificate.

Rights and restrictions

We were pleased to note that those subject to detention under the Mental Health Act had been advised of their rights verbally and in writing; those who were subject to detention were either accessing, or knew how to access, advocacy services.

During our last visit, Covid-19 visiting restrictions were in operation in Ward 4A and Ward 4B, and we recommended that visiting hours should be updated in line with Scottish Government guidelines. We were pleased to note that this has since been updated and visiting is now only restricted around protected mealtimes. Individuals that we met with felt contact with their family was supported and were happy with relatives' involvement in their care.

Sections 281 to 286 of the Mental Health Act relate to specified persons, a legal safeguard required 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. During our visit, two individuals in Ward 4A, and two individuals in Ward 4B, were found to be specified. All documentation relating to this, including reasoned opinion, was in place.

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

Those that we spoke with on Ward 4A and Ward 4B told us that they enjoyed a range of activities on the ward and at the onsite recreational therapy (RT) centre. Activities were supported by patient activity coordinators, who most individuals spoke positively about. Additionally, in reach is provided by RT and allied health professional staff. We heard from several individuals that nursing staff will often arrange ward-based activities, such as organising movie nights in communal areas. The onsite gym also offers regular sessions led by the physiotherapy team.

The RT centre offers music and art groups, creative writing, gardening, football, and walking groups. We visited the RT centre where we met with individuals and staff, and found the activities offered to be varied and meaningful. We noted Covid-19 restrictions that were previously in place restricting the access for each ward, have been removed. We were impressed that RT staff supported individuals to access the local community, via football and gardening groups.

During our last visit we made recommendations to record engagement and/or non-engagement of individuals in activities. We also recommended managers ensured access to meaningful activities was offered seven days a week. We were pleased to see engagement in activities is now being recorded. Whilst there is clear motivation and commitment by all staff to engage people in activities, we heard from several individuals that weekends can be harder due to a reduction in the number of activities on offer. Those that we spoke with reported that pressures on nursing staff could result in limited access to activities in the evenings and at weekends.

Recommendation 4:
Managers should ensure that individuals have access to meaningful activity and occupation seven days per week.

The physical environment

Ward 4A and 4B share a communal entry area and are purpose built with identical layouts. Both wards are clean, spacious, bright, and well decorated. There are accessible bedrooms for assisted individuals, with quieter spaces to accommodate varying needs.

The communal garden facilities were tidy and clean and can be enjoyed by individuals and visitors throughout the year, weather permitting.

We observed magnetic, partial en-suite toilet doors in bedrooms which some individuals reported as a violation of their right to privacy and dignity. There are visible gaps at the top and bottoms of the doors. We also noted the doors fell off easily and we view this a safety issue. In discussion with managers, we were advised that a review of the doors is underway, with plans to increase safety by using heavier magnets to attach the doors. Whilst these steps may improve safety, it does not address issues of privacy and dignity which some patients reported as unacceptable. We look forward to seeing improvements implemented on our next visit.

Recommendation 5:
Managers should review the en-suite magnetic partial doors considering the identified safety risk and impact on individual rights to privacy and dignity.

Any other comments

We were advised that retention and recruitment of staff is a key priority across the service, with NHSGGC using their own bank staff as opposed to agency staff. SCNs for both wards informed us that this has helped maintain consistency of staff. On the day of the visit, we spoke with newly qualified nursing staff, who told us they felt supported by SCNs, and this was a reason for remaining in post. The consultant we spoke with also commented on good nursing care and teamwork across both wards.

Given the many positive comments made by individuals during our visit we are impressed by the care provided by staff in Ward 4A and Ward 4B.

Summary of recommendations

Recommendation 1:
Managers should ensure all care plans are accessible and consistently stored.

Recommendation 2:
Managers should ensure that risk assessment documentation is reviewed regularly and updated accordingly.

Recommendation 3:
Managers should ensure the review and audit of medication records for individuals requiring T2 and T3 certificates to authorise their treatment under the Mental Health Act is carried out and findings acted upon in a timely way.

Recommendation 4:
Managers should ensure that individuals have access to meaningful activity and occupation seven days per week.

Recommendation 5:
Managers should review the en-suite magnetic partial doors considering the identified safety risk and impact on individual rights to privacy and dignity.

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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