Mental Welfare Commission for Scotland

Report on announced visit to:

West of Scotland Mother and Baby Unit, Leverndale Hospital, 510 Crookston Road, Glasgow, G53 7TU

Date of visit: 1 May 2024

Where we visited

The West of Scotland Mother and Baby Unit (MBU) is a six-bedded regional unit for the West of Scotland, located in Leverndale Hospital, Glasgow. The MBU receives admissions from Dumfries and Galloway, Ayrshire and Arran, Greater Glasgow and Clyde, Highland (Argyll region), Lanarkshire and Western Island Health Boards; it can also receive admissions from Forth Valley and Grampian Health Boards who can spot purchase beds when necessary. The unit may also receive boarding patients when Scotland's other MBU located in St John's Hospital, Livingston is full.

The ward is co-located with the local community perinatal team which is located on the first floor of the same building and this team offers outpatient clinics and outreach support for women living in the Greater Glasgow and Clyde area.

The MBU accepts referrals from women at late stage of their pregnancy and during their first postpartum year.

On the day of our visit there were three vacant beds and two individuals were on pass.

We last visited this service on an announced basis in January 2023 and made no recommendations. In our previous visit in November 2021 we had made recommendations about the service adapting to EMIS, the electronic record system, and incorporating the recording and review of care planning documentation into the relevant electronic case records, rather than the unit being reliant on paper records instead. We were told that the unit's senior charge nurse had met with programme leads from EMIS and a short life working group had been set up to facilitate the shift from remaining paper case records onto electronic templates in EMIS, specific to the perinatal service.

Last year we were told that the short life working group's activity remained ongoing, however we have since learned that no further progress has been made. Individual care plans remain in paper form as working documents that are scanned and then uploaded onto EMIS as a part of the electronic clinical record. We have been told that a waiting list exists to support the ward making changes to EMIS to support electronic recording of care plans so that paper records are no longer needed.

On the day of this visit, we wanted to look at the unit's clinical documentation and hear about how the service supports and involves individuals in their care.

Who we met with

We met with, and reviewed the care of three people, none of whom we met with in person but all three of whom we reviewed the care notes of. We were not able to speak with any relatives.

We spoke with the senior charge nurse, two of the charge nurses and the unit's consultant psychiatrist. We also spoke with the unit's social worker as part of our visit.

Commission visitors

Dr Helen Dawson, medical officer

Justin McNicol, social work officer

What people told us and what we found

Care, treatment, support and participation

Admission documentation

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

Care records

Mothers and their babies are often admitted and stay together at the MBU and the key purpose of any admission is primarily to assess and treat the mental health needs of the mother while supporting the bond or attachment between the mother and child.

For any admission, the mother is regarded as the identified patient, however clinical personnel are also dedicated to the care of the baby in the clinical team. As a consequence of this pairing, the MBU has specific needs in relation to clinical record keeping, with the need to document information relating to the care and treatment of both the mother and the mother's baby when both stay on the ward. There is also the need to ensure that documentation relating to the mother and her baby is well integrated and that systems are in place to ensure co-ordination and synchronisation of the two sets of case notes.

Clinical case notes relating to the mother were primarily located in the electronic system, EMIS. However, a system was in place so that nursing care plans relating to a mother's care were held in paper format in a folder. We were told that these were shared and discussed with the mother before being scanned and uploaded onto EMIS and into the individual's electronic file. One of the dangers of this process is the risk of fragmentation and introduction of inconsistencies of records and we saw evidence of this in the files we reviewed. Some records did not have care plans relating to support around the use of the mental health legislation when this was appropriate; some records did. We also learned that some files did not show any evidence of review of care plans because the mother had been on pass from the ward over that time period and no review would take place without the mother's involvement.

Additionally, we saw that care plans on EMIS did not always synchronise with care plans in the paper folder due to new care plans being developed but not yet agreed with the mother and so not yet uploaded onto the patient's file on EMIS. As a consequence, it was difficult to be confident about what care plans were active and were a representative reflection of an individual's care and which were not. Despite the concerns about recording of care plans, we recognised the effort had been taken by the MBU team in involving patients in their care. We saw folders with copies of the individual's care plan kept in the patients' bedrooms, and evidence of their participation in the clinical records.

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 formats presents a risk of information going

missing or being overlooked and we have concerns that the record keeping does not always accurately reflect the care provided.

During our visit we learned that the notes regarding the baby/infant are located in a separate electronic system 'child-EMIS' to that of the mother and that all nursing staff have access to both systems. We were also told that, at the weekly multi-disciplinary team meeting, information from both sources is used to inform the meeting and guide the decisions made there. Unfortunately, we found the style of some records for multidisciplinary meetings to be confusing. We learned that a template that is used for recording minutes, which reflects templates used for MDTs in other wards in Leverndale Hospital, is used as an MDT template in the MBU, and uses the term 'care plan'; it did not relate to the nursing care plans in the patients notes but more accurately seemed to reflect a decision outcome for the MDT meeting. These 'care plans' in the MDT template began at number 2 and together with the problems around the paper care planning system gave an impression of confused and unclear record keeping in some areas.

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:
Hospital managers should review the care planning in the service and the documentation of multidisciplinary meetings to ensure there is good correlation between the two and that care plans are consistent, whether held on paper file or electronically, and accurately reflect individuals' care at any given point in time.

Risk assessment

Individuals had clear and comprehensive risk assessments (CRAFT) in place and we saw evidence that these had been updated and informed the relevant care plans, where appropriate. We were told that risk assessment completion and review formed part of the unit's ongoing monthly audit processes for individual records to support the high standard in record keeping and care.

Multidisciplinary team (MDT)

The MDT in the unit is large, in reflection of the complex needs of the mothers and babies admitted there. In addition to the psychiatry and nursing staff, the unit has its own social worker, clinical psychologist, pharmacist, occupational therapist, health visitor, nursery nurses and a parent-infant therapist. A local GP surgery supports care for the babies and in recent years peer and hospital support workers have joined the clinical team. The unit has access to the hospital physiotherapist.

Every woman is provided with a named nurse and associate nurse upon admission. A key challenge in a clinical team, with such a diverse range of staff supporting either mother or baby individually or jointly, is the need for role clarity and good communication. As the clinical team has expanded, we were told that this had developed incrementally and is an ongoing process. The regular multidisciplinary meetings are key to support integration of activity in the

unit and also with community services. Each week every person is 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 to host the multidisciplinary meetings has proved beneficial to the service and supports greater participation and involvement from external agencies in an individual's care.

Use of mental health and incapacity legislation

On the day of our visit very few individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

All documentation relating to the Mental Health Act, including certificates around capacity to consent to treatment was easily accessible and organised on EMIS.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We were told that it is rarely the case that a patient on the ward requires to have a certificate certifying authority for treatment.

We were told that urgent mental health officer (MHO) cover for the ward continues to be provided by Glasgow Health and Social Care Partnership (HSCP). This is an important resource given the regional nature of the unit, with many people coming from areas far from Glasgow, and access to an MHO from the individual's home area could be very difficult on an emergency basis.

We did discuss alerts on HePMA, the electronic medication dispensing system, and it was good to hear that the unit has alerts for when mothers are breastfeeding which automatically alerts practitioners using the record to consider the risk of medication in relation to the baby.

We also discussed section 278 of the Mental Health Act that requires hospital services to mitigate the impact of any detention in hospital on the relationship between parents and their children. We asked the ward to look into our previous report on this area of practise and consider how they might implement any of its findings in relation to care provided including formally considering the use of specific care plans to support parents in their parenting roles.

Rights and restrictions

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

Individuals are provided with written information about the unit, their hospital stay and their rights at the time of admission; this information was also available in their rooms. The unit has produced an online virtual tour of the unit that is available on NHS Greater Glasgow and Clyde's (NHS GGC) website. This introduces the unit and helps mothers to find out about it prior to admission. We found the information provided to mothers to be attractive and of a high standard with a range of topics considered and included.

Mothers are referred to advocacy on an individual basis and information is given about advocacy and their rights to this.

Scottish Government funding remains a useful resource to help support the travelling expenses, the meal and accommodation costs of close family or carers visiting the unit. We heard that there continues to be good uptake of this.

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 provides a comprehensive range of activities, delivered by various professionals throughout the day and evening. We were told that where staff have particular areas of interest, this is encouraged, developed and promoted in the unit to enrich the activities and resources available to mothers and their babies on the ward.

In addition to more formal events, there was plenty of opportunity for socialising more informally throughout the unit. Activities were discussed on a daily basis in meetings with nursing staff, and participation in activities was recorded. The ward had a number of attractively designed noticeboards, with organised activities displayed and information about various aspects of health, across different locations that facilitated ease of access and promoted information sharing whenever possible.

The physical environment

The MBU is located in a purpose built two-storey building in Leverndale Hospital. It is a light and spacious ward and located on the ground floor. The ward overlooks a private garden which is pleasantly stocked with plants and areas to sit outside in a range of weathers.

The ward appeared clean, welcoming and well decorated with a number of recreational areas where mothers and babies can relax and spend time together or with others. We were told that there were no issues reported with respect to noise levels or light levels in the unit, and the heating and ventilation appeared appropriate for an environment that catered for the needs of babies.

Every bedroom has private en-suite facilities and is provided with a cot. One bedroom has facilities for disabled access. A nursery is situated at the centre of the unit and there is 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 is large and bright with a dining area that looks out over the garden. A family room and separate playroom provides space for individual and group activities.

Summary of recommendations

Recommendation 1:

Hospital managers should review the care planning in the service and the documentation of multidisciplinary meetings to ensure there is good correlation between the two and that care plans are consistent, whether held on paper file or electronically, and accurately reflect individuals' care at any given point in time.

Any other comments

The ward staff remain committed and work hard to deliver improvements in individual care. Ongoing initiatives include training and development of trauma informed care and support for further specialist training in infant feeding. Work is ongoing into the development of recovery journals to support individuals in their recovery and recent developments have included a project to review the MDT process to better support people and also the development of a Fathers', Partners', and Carers' Pathway to help ensure their appropriate inclusion during an admission. At the recent Scottish Mental Health Nurse Forum, the MBU was given an award for all the recent quality improvement works and the MBU has also been nominated for the RCN Nurse of the Year for its work with mothers and young parents.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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