Mental Welfare Commission for Scotland

Report on announced/unannounced visit to: Leverndale Hospital, Ward 3A, 510 Crookston Rd, Glasgow G53 7TU

Date of visit: 2 May 2022

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 3A is an adult acute mental health admission ward and covers the geographical area of Renfrewshire, Barrhead, Pollock and Crookston. The ward has 24 beds and is divided into two in-patient areas that have single and dormitory (four beds in each) bedrooms. The ward admits both female and male patients; this arrangement allows for areas to be used flexibly to accommodate when there are variations on the number of female and male patients. There were seven patients who were in the ward informally and the remainder were detained either on short term detention certificates (STDCs) or compulsory treatment orders (CTOs).

On the day of our visit there were 24 patients in the ward with one patient who had just been admitted and who was on day one of isolation, in line with Covid 19 guidance. Two patients were on enhanced observations. There were two patients who were identified as having their discharges delayed.

Ward 3A has had to close twice due to Covid-19, once in 2021 and again in February 2022. We last visited this service on 20 January 2020 and made three recommendations. The previous visit was in conjunction with visits on consecutive days to Ward 4A and Ward 4B. The report reflected findings from all three wards but this visit will reflect findings only from Ward 3A. On the day of this visit we wanted to follow up on the previous recommendations and also hear how patients and staff have managed throughout the current pandemic; we were aware that the pandemic has had a significant impact on the provision of activities and visiting.

We also wanted to find out if there had been progress made towards improving care planning documentation, risk assessments and multi-disciplinary team (MDT) recording, and the review of medication records for patients whose treatment is authorised under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Act').

On the day of this visit we looked at care plans, activity provision and visiting arrangements. We were also supported to view patient records on EMIS, the electronic recording tool used in the ward.

Who we met with

We met with and reviewed the care and treatment of 12 patients and spoke with one carer. The visit took place on a local public holiday and access to the full range of the multi-disciplinary team was not possible. However, we spoke with the senior charge nurse (SCN) and the deputy charge nurse (DCN).

Commission visitors

Anne Craig, social work officer
Yvonne Bennett, social work officer
Gillian Gibson, nursing officer

What people told us and what we found

Care, treatment, support and participation

Without exception all patients we spoke to had only praise for the staff team. One patient who had been in the ward for several months described the staff team as “amazing” and “the quality of care is really good”.

The SCN spoke highly of the staff team. We heard that staffing the ward has been challenging but manageable. We discussed the staffing situation during Covid-19 and heard that staff had worked together, at times doing extra shifts for 3A and other wards, to provide adequate safe cover. The current therapeutic activity nurse (TAN) is leaving their post but will be replaced; this post has been noted to have had a significant benefit to the patients over the past year, especially during the lockdown periods where the campus recreational therapy area had closed.

Nursing care plans

When we reviewed the care plans we were unable to locate robust reviews which targeted nursing interventions and individual’s progress. We discussed this with the nurses on duty and the senior charge nurse. There was an awareness that reviews were happening but this was not reflected in the paperwork. We are aware that in the service as a whole, work on care plans and reviews is being progressed. The care plans we reviewed were not of a standard that reflect the service that is delivered and were not particularly person-centred. They were often completed quickly after admission and, whilst there was evidence of regular evaluations, the care plans appeared to be updated on an ad-hoc basis to reflect new information or changing needs. The last visit made a recommendation on care plans and this visit found that little had changed. We also felt that the care plans were of a generic nature and applicable to any patient.

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 carry out an audit of the nursing care plan reviews to ensure they fully reflect the patient’s progress towards stated care goals and that recording of reviews are consistent across all care plans.

Care Notes

Chronological notes evidenced regular one-to-one discussions between the patient and nursing staff, and it was clear that the patient’s views on their care and treatment were sought and recorded in the care notes. We were told that advocacy services can become involved with those patients who require it. The ward notice board had a range of information about patient’s rights and advocacy services, along with contact details and how they could help.

Multidisciplinary team (MDT)

The ward is served by four consultants, each covering a geographical area. MDTs are held weekly for each consultant. Consultants visit the ward and their patients throughout the week out with MDT meetings. MDT meetings are attended by medical and nursing staff, pharmacy, occupational therapy, physiotherapy and psychology when required. The ward has an allocated liaison social worker who acts as the first point of contact for referrals and attends MDT meetings via Teams. However, this social worker only covers patients who live in the Glasgow area and the ward has patients from East Renfrewshire. Contact with East Renfrewshire HSCP is more challenging, particularly in relation to discharge arrangements.

Relatives are not currently invited to attend MDT reviews due to Covid-19 guidance, however they are contacted by the medical staff to discuss their views prior to the review. Relatives are also contacted by named nurses after the review, with updates from the MDT and information on decisions that have been taken and actions that have been agreed. MDT reviews are recorded in the EMIS electronic recording system although this took some time to find; the MDT template is abridged and found under "progress notes". We were assured that this had been noted with the EMIS team, and while the abridged version was useful, we would suggest that a full MDT template for each patient should be recorded in the patient's notes.

Input from other allied health professionals and specialist teams is available when required on a referral basis; there was no reported difficulty with access to these. Currently the ward has two patients whose discharge has been delayed and who are awaiting either appropriate placement or for a welfare guardianship to be granted, to provide the legal authority for a move to a care home.

Use of mental health and incapacity legislation

Recording of a patient's status was found in EMIS and was clear and concise. There were no concerns noted in detention paperwork or its availability.

Part 16 (S235-248) of the Mental Health Act (Care and Treatment) (Scotland) Act 2003 sets out the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments. We reviewed the medication prescription forms and the consent to treatment certificates (T2) and certificates authorising treatment (T3). There were no issues with the medication paperwork.

No patients had section 47 certificates in place. Section 47 certificates authorise medical treatment for physical conditions where patients do not have capacity to consent. We felt that two of the patients that we spoke to should have s47 certificates in place and raised this with the SCN to action. The SCN advised us that they would speak with the patients' RMO. We will follow this up after the visit.

The Mental Welfare Commission has produced a Good Practice Guide which can be found at:
TreatmentUnderSection47oftheAdultsWithIncapacityAct_April2021.pdf (mwcscot.org.uk)

Rights and restrictions

We heard comments about a ward "sweep". When we asked the SCN about this, we were advised that this was more in the sense of a "tidy up" in the ward, although the inference of the terminology was that patient's belongings were being searched. We asked if patients were asked to sign to say that they consented to this search; we were advised that a search only took place if there was good reason to do so, i.e. where the ward staff were aware of a patient stockpiling medication etc. We suggested that when patients' belongings are being searched or for any intrusion involving belongings took place, a patient should sign to say that they have consented, if they have capacity to do so. Where consent is not given, the responsible medical officer (RMO) should consider the specified person provision under the Mental Health Act to ensure that the patient has the right of appeal against this intervention. We were also advised that the ward does have a search policy which can be used in circumstances where there are concerns around the patient, other patients or the ward's safety and security. We look forward to seeing further clarity around this situation at future visits.

Some patients have restrictions in place, specifically in relation to use of mobile phones. The appropriate specified persons paperwork was in place and the staff support patients to make calls when it is appropriate to do so. Further information on specified persons can be found at: specified_persons_guidance_2015-edited_0.pdf (mwcscot.org.uk)

The ward door is locked and entry is via a buzzer or key fob system. There is a locked door policy and information on this is provided to families and other visitors. Although restrictions due to Covid-19 are reducing, we found that visiting is still an issue. This is in part due to the ward environment as ward 3A shares a dining space with ward 3B, where visits take place. The ward provides visiting for 45 minutes, in two sessions per day, one in the afternoon and one in the evening. Although this is not restricted to one visitor per patient, there can be several visitors and patients in the visiting area at a time. Visiting is in a communal space and is not private, however patients and their visitors can utilise the grounds, depending on their ability and status. Visits continue to have to be pre-booked and are time limited.

Recommendation 2:
Managers should ensure that visiting arrangements are in line with current Scottish Government guidance.
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 benefits from a TAN and has an activity room that is well-equipped and regularly used by patients during the day. There is an adjacent garden area to the main lounge area where patients can spend time gardening, or sitting outside if they wish; the garden is shared with ward 3B. This is also the smoking area for both wards and could prevent some patients from using the outdoor space if they do not like to be in an area where smoking is permitted.

On the day of our visit, no patients highlighted this as an issue. We did not see any patient's notes referring to refusal or participation in activities.

We spoke with the acting charge nurse (CN) for the recreational therapy area which was just about to re-open to patients from across the site. We were advised that there is a schedule where each ward will be allocated days or sessions but following and after each session there will be a deep clean undertaken. During the pandemic staff had taken an in-reach approach to the patients in their own wards. There are significant skills and abilities in the recreational therapy staff team and their ethos is to have no barriers to engaging with recreational activity and therapy; this supports the promotion of good mental health and wellbeing. It is intended that some in-reach will continue to the wards and will complement the main recreational therapy area and activities in their own building.

Recommendation 3:
Managers should ensure that when a patient accepts or declines activities offered, this is noted in the patient's file.

The physical environment

The physical environment is compromised in two ways. The first is caused by the sharing of communal areas with ward 3B and the second relates to the dormitory accommodation. The communal dining room and visiting area between wards 3A and 3B is due to the age and construction of the building. Staff and patients make the best of the situation although this situation would only change with a reconstruction of the current accommodation.
We heard from some patients that they like the company that comes from being in dormitory accommodation, others did not. The Commission's view is that when caring for patients who are acutely unwell, dormitory accommodation may not be appropriate or safe.

Ward 3A has recently had a repaint and some patient artwork is displayed in the activity room but this does not change the issue of this ward being one of the older areas on the site. We heard that the domestic team work hard to keep the ward at its optimum cleanliness.

Summary of recommendations

1. Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patient's progress towards stated care goals and that recording of reviews are consistent across all care plans.

2. Managers should ensure that visiting arrangements are in line with current Scottish Government Guidance.

3. Managers should ensure that when a patient accepts or declines activities offered, this is noted in the patient's file.

Service response to recommendations

The Commission requires a response to these recommendations within three months of receipt 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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