Mental Welfare Commission for Scotland

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

Date of visit: 31 January 2024

Where we visited

The intensive psychiatric care unit (IPCU) at Leverndale Hospital is a 12-bedded unit for individuals (aged 18-65 years) who require intensive treatment and intervention. Individuals are generally from the South Glasgow area. The function, layout of the ward, and facilities were unchanged since our previous visit in July 2023. 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 nine to12 twelve male beds, in a mix of single rooms and small dormitories. On the day of our visit there were nine male individuals and three female individuals.

We last visited this service on 18 July 2023; we made three recommendations regarding the need to address the allocation of mental health officers for all individuals, the need to ensure prioritisation of advocacy services and that a programme of work is undertaken to ensure that the IPCU provided a conducive setting for individuals.

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 three previous visits in 2022 (announced), January 2023 (unannounced) and July 2023 (unannounced). We also wanted to check progress with the NHS Greater Glasgow and Clyde (NHSGGC) Significant Adverse Event Review (SAER) process which had highlighted concerns regarding the deaths of two individuals in the IPCU over the last four years.

We wanted to meet with as many individuals on the ward as possible, to hear about their experiences and the views they had about their care and treatment.

Who we met with

We met with and reviewed the care of nine individuals. We spoke with the inpatient service manager, operational nurse manager, the deputy charge nurse, and nursing staff throughout the day.

Commission visitors

Justin McNicholl, social work officer

Sheena Jones, consultant psychiatrist

What people told us and what we found

Care, treatment, support and participation

As this visit was unannounced, individuals and staff were not prepared in advance. Despite this, we were given full access to the ward to meet with individuals and staff.

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

We were told by individuals that staff "treat me like a member of their family" and "they are always there to listen and provide advice, anytime day or night". One individual stated, "I trust them and many of them are brand-new" whilst another stated, "I know sometimes they have to restrain me, but they make sure I'm physically well afterwards and get me a doctor, if required". Individuals gave us good examples of how they felt their care was well-managed during periods where they experienced high levels of distress.

All of the individuals we spoke with praised the work of the activities nurse, making comments such as, "they are great; there are always things to do and it's not silly stuff". We found evidence of this in the files of individuals, with the example of the smoothie and conversational group that was held to promote healthy eating and positive mental wellbeing. Individuals told us they found the environment "needs updating even though it's not that old", "the single rooms are cold" and "the showers really need updating". We are aware that there has been no significant improvement works carried out to the ward since our visit in July 2023. Managers advised that capital funding had been secured to improve the ward environment.

Individuals advised that there was a consistency in staffing levels. Nursing staff who had worked in the ward for several years advised that "there is now a different feel to the ward". This was echoed by new nurses to the ward who spoke of the "excellent" peer and management support they received since their inductions. Individuals that we met with stated, "it is so much calmer in here compared to other IPCU's; the alarms hardly ever go off".

There was praise from some of the individuals we met with regarding the care and communication received from the psychiatrist responsible for the ward. One individual told us, "My RMO is good, I have confidence in their approach as they understand bipolar well", whilst another stated, "They are great. They seem to know what they are doing, and got me out of trouble."

During previous visits in 2022 and 2023, there were concerns noted around the levels of agency staff and the recruitment and retention of nursing staff. During this visit, which was similar to our visit July 2023. we found no reliance on agency staff. We heard that consistent bank staff were deployed to the ward to ensure safe staffing levels were in place to meet the needs of patient care. All the members of staff we spoke with knew their patients well, and reported having trust in their colleagues in the wider multi-disciplinary team. There was clear evidence that relatives and carers were proactively approached by the nursing team, which ensured that any concerns or questions were answered promptly.

On the day of this visit, there were no individuals in the IPCU whose discharge from hospital was defined as delayed. There were two individuals who were waiting to move to other acute wards. We heard from staff that there was a high admission and discharge rate to the ward which is what we would expect to see in an IPCU. The longest stay for any patient in the ward was six months, which was a significant improvement in comparison to our visit in 2022, when there were a number of individuals who had had a longer stay. We heard from staff that having regular meetings with bed managers helped to avoid unnecessary delays for individuals. We found that many of the individuals, while not ready for discharge, had access to hospital grounds, had visits home and meetings with their relatives or time out in the local community.

Similar to our visit in July 2023, there is a high ratio of staff to individuals which is appropriate due to the levels of clinical risk and patient need. There was one patient on enhanced observations at the time of our visit. We were able to observe how the patient was being nursed in the de-escalation sensory room (DSR) and we were assured by the care that was being delivered which appeared informed and person centred. Since our last two unannounced visits to the IPCU there have been no further adverse events reported to the Commission.

Multidisciplinary team (MDT)

The IPCU has a broad range of staff providing input. The ward has one consultant psychiatrist, one doctor with a specific remit for the ward and two junior doctors. There were six members of staff on shift during our visit with three of these being trained nursing staff. We heard from nursing staff that patients had "good access" to medical, psychology, pharmacy and occupational therapy staff and activity co-ordinators. For individuals 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. The notes also included the views of the patient and their families. We found proactive steps taken by the ward staff to speak with families and maintain regular contact on a weekly basis.

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 NHSGGC for all records to be held on EMIS but no exact date has been confirmed as to when this will occur in the IPCU. We look forward to hearing how this will be implemented for the ward and how staff and individuals adjust to this transition in due course.

We found all records on the electronic and paper systems up-to-date. When examining the records, we found clear and consistent use of the alert system on EMIS to make staff aware of any risks which included medication reactions, considerations around physical health and individuals' risks to themselves or others.

We found the records easy to navigate, and there was a clear focus on individuals' mental and physical well-being. We found that when physical health was a cause for concern there was

quick access to the duty doctor. All the risk assessments we reviewed were detailed, regularly reviewed, and we saw individual risk management plans included in individual records.

On our visit in January 2023, we found that there were poor examples of person-centred care plans. We were pleased to find significant improvement with care plans, which provide detailed person-centred records in our visit in July 2023. For this visit, we found that there were further improvements in care plans and in reviews of them, which been well maintained by staff. All of the records that we reviewed evidenced patient and carer involvement. We found documented one-to-one sessions with the individual's named nurse and this was confirmed by individuals who were able to name their allocated nurse.

Use of mental health and incapacity legislation

On the day of our visit, all 12 individuals in the IPCU were detained either 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 individuals, 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.

We found all medication was prescribed in line with the local NHSGGC policy. We found that all recordings relating to the prescribing of emergency sedation in the drug administration system were linked to the NHSGGC rapid tranquilisation policy. From the records we viewed, we found that the frequency and maximum dosage of prescribed medication was recorded clearly on HEPMA, the electronic prescription system.

Rights and restrictions

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

We heard from staff that the promotion and referrals to advocacy for individuals were prioritised by the ward. We found good evidence of this, with individuals advising that they had easy access to advocacy and were advised of their rights. We found this was an improvement from our previous visits in January 2023 and July 2023, when individuals spoke of not being supported throughout their journey in the service.

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, which we found easy to located in care records.

We looked at advance statements on this visit; these refer to statements made under sections 274 and 276 of the Mental Health Act, and are written when a person has capacity to make decisions on the treatments they want or do not want. We found one advance statement for a patient in the IPCU. It was also clearly recorded on the EMIS system who had an advance statement, and this was revisited on a regular basis with individuals.

During our last visit we noted that some individuals had no allocated mental health officers appointed. We had made a recommendation to Glasgow Health and Social Care Partnership to ensure that all individuals are supported appropriately while subject to mental health and incapacity legislation. On this visit we found that all individuals had access to an allocated mental health officer.

We were pleased to hear from staff that in line with our previous visit, that there has been a significant decrease in the use of the de-escalation room and incidence of violence. Staff reported that the de-escalation room was being utilised by individuals in a different way and some patients sought to use it as a means to manage their distress.

Activity and occupation

Activities for individuals in IPCU wards can be a significant issue due to the level of restrictions people that may need to be put in place. We were pleased to hear of the ongoing positive work of the therapeutic activity nurse (TAN). This role has ensured that there was an opportunity to offer activities to all individuals. During our visit we were able to observe a full list of daily activities in the ward. We were also able to find clear evidence of activity participation with individuals, recorded in their notes.

We noted opportunities for individuals, when appropriate, to access the recreational therapy (RT) department on the Leverndale site. This input was well regarded by the individuals and staff that we spoke with.

The physical environment

The physical environment of the ward remains largely unchanged since our last visit. The ward continues to be stark and signs with general wear and tear were apparent throughout all areas of the ward. The basic decor of the ward continues not to provide a positive experience for individuals, with the use of dormitories that made privacy and promoting a good sleep pattern problematic. The lack of en-suite facilities continued to be raised by those individuals that we spoke with. The noise levels and the aging facilities were far from ideal for maximising patient care. We heard from managers that there are plans to improve the physical layout of the ward and that capital funding has been secured to proceed with a ward redesign which is likely to require individuals being temporarily moved from the IPCU to enable this to take place.

Recommendation 1:
Managers should inform the Commission of the action planned around work to update the current environment to ensure that it provides a conducive setting for individuals.

Summary of recommendations

Recommendation 1:

Managers should inform the Commission of the action planned around of works to update the current environment to ensure that it provides a conducive setting for individuals.

Service response to recommendations

The Commission requires a response to this recommendation 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