



Mental Welfare Commission for Scotland

Report on announced visit to: Leverndale Hospital, Ward 2,
510 Crookston Road, Glasgow, G53 7TU

Date of visit: 15 December 2016

Where we visited

Ward 2 is a 15 bedded mixed sex ward comprising 14 continuing care beds and a contingency bed. It is managed as part of the rehabilitation service in Leverndale. The ward has six single rooms and two four-bedded dormitories, one of which accommodates the contingency bed (male) which is used when there is demand pressure for bed availability in the hospital.

It provides a service for adults who have been unable to cope with either intensive or moderate rehabilitation programmes. The patients have complex mental health difficulties and physical health issues and residential and nursing homes have been unable to support the challenges posed by these. However patients are assessed regularly with a view to considering other options to hospital care.

On the day of our visit there were 14 patients on the ward. One patient was boarding in the ward due to a lack of beds in the acute service. The current age range, excluding the patient who was boarding, was from 65 to 92 years of age.

We visited on this occasion to give patients and relatives an opportunity to raise any issues with us and to ensure the care and treatment and the facilities are meeting patients' needs.

We also looked at:

- Care and treatment and service user participation
- Therapeutic activity
- Use of legislation
- Physical environment

We last visited this unit in December 2012 when there was a different patient group and the environment was of a different layout. At that time we were very positive about the care and treatment and made some recommendations on the documentation of care plans.

The Commission visitors were

Alison Goodwin, social work officer

Jamie Aarons, social work officer

Who we met with

We met with four patients and looked at the records of two further patients.

We spoke with the ward manager, the consultant psychiatrist, the physiotherapist and some of the staff nurses.

What people told us and what we found

Care, treatment, support and participation

We met with four patients and reviewed the records of two other patients. The patients we spoke to did not raise any specific concerns about the ward and were very positive about the care and treatment provided by the nursing staff, the psychiatrist and the allied health professionals.

There is a very diverse group of patients in the ward. Many patients have been in hospital for a considerable number of years and the chronic nature of their illness means their motivation to engage and participate in activities of daily living, therapeutic, social and recreational activities can be limited. However we saw great efforts by staff to encourage involvement in both their treatment and activities.

Many of the patients have physical health issues and mobility problems. In addition to the consultant, who covers the three wards in the rehabilitation service, there is a junior doctor who has two sessions per week in the ward. There is also a staff grade doctor available for cover. All patients have an annual health check and we saw evidence in the records of good follow up of any physical health issues that arose as well as excellent input by the physiotherapist.

We heard there is good input to the multi-disciplinary team (MDT) from pharmacy (approximately fortnightly attendance at the MDT meeting and individual follow up), physiotherapy (one or two groups weekly plus individual work), occupational therapy (OT three sessions per week), recreational therapy (two sessions per week), the Patient Activity Coordinator (PAC two sessions per week), nursing staff, and speech and language therapy and psychology as required. The consultant psychiatrist has four clinical sessions divided between Balloch Ward and Ward 2.

Care plans are person-centred and detailed in terms of physical health, mental health and social needs. There are good OT and physiotherapy assessments where appropriate. We were pleased to see that there are regular reviews of care and treatment plans recorded in both the MDT paperwork and in the chronological notes. It was evident that the MDT continued to consider any possible alternative placements, even though patients have been in hospital for long periods of time and have had a number of placements which have not worked.

The updates of the Five Areas of Assessment in each patient record give an excellent overview of the patient's background, history in mental health services and current situation.

Patients are offered the opportunity of attending the multi-disciplinary team (MDT) meetings, and we saw evidence that quite a few did attend.

We also saw 1:1 sessions between the patient and the key nurse highlighted in the chronological notes and these indicated discussion of the patient's views. We thought the 'My Views' form to encourage patient participation was not at all user friendly and was more of a checklist for staff.

Most of the patients do have family or carer involvement. Staff actively promote and support family involvement in discussion of the patient's care and treatment and provide additional opportunities for family contact through social events such as Halloween and Christmas parties.

Advocacy is involved with those who are detained and if required for specific issues.

Recommendation 1:

The service should consider an alternative, more user-friendly form for gathering patients' views on their care and treatment.

Therapeutic activity

As mentioned above, there is good support from the OT, PAC, physiotherapist, recreational therapy and nursing staff to therapeutic, social and recreational activities on the ward. This includes breakfast and lunch groups, art and craft groups, walking and exercise groups, reminiscence groups, cinema nights and pet therapy. There is nursing time set aside between 11am and 2pm each day to ensure one or two of the patients get out to do their personal shopping and have lunch out, though sometimes this is disrupted by staff being taken away to cover the acute wards. There are also opportunities for outings with the OT. The ward has access to a people carrier. The Volunteer Coordinator in the hospital has matched two volunteers to patients in the ward, though one has just recently left.

Activities were recorded in the patient's chronological record and the ward also had an activity plan which detailed the activities that had taken place and who had participated in these. Although there were patients who were reluctant to participate, we saw successful efforts to engage with them with positive results for the individual.

Our only concern was the underuse of the therapeutic kitchen in the ward. This is a valuable and well-equipped resource which is only used once a week by the OT and is otherwise locked. Currently it cannot be used by patients with nursing staff, though we were told they would like to have the opportunity to do cooking and baking with some of the patients.

Recommendation 2:

The service should review the arrangements for accessing the therapeutic kitchen to ensure maximum benefit of this resource for the patients.

Use of mental health and incapacity legislation

We were pleased to find all consent to treatment forms under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) and section 47 certificates and treatment plans under the Adults with Incapacity (Scotland) Act 2000 (AWI) were in place.

There were good detailed Suspension of Detention (MHA) plans.

There were good personal spending plans for those patients whose funds were managed under Part 4 of the AWI Act. However there were a number who had accumulated considerable amounts of money. We considered there could be advantages in some of these individuals using their funds to employ extra support or nursing staff to enable them to get out of hospital more and enjoy increased community activities.

Recommendation 3:

The service should explore the opportunity for patients to use their money to employ staff to increase their access to community activities.

The physical environment

The ward is clean, bright and well maintained. The large and small sitting rooms are comfortable and well furnished. There were small groups of chairs to break up the long corridors. There is a large activity room and a therapeutic kitchen.

There are six single rooms with shower and toilet facilities nearby. The two four-bedded dormitory areas are relatively spacious, having originally had six beds in each, and several of the patients we spoke to said they preferred to be in the dormitory. They have shared shower and toilet facilities. Apart from bedside lamps, there was very little personalisation of the single or shared bed spaces and they appeared quite institutional compared with the communal areas of the ward. There was nothing on any of the walls and the bedding consisted of the standard hospital blankets. As this ward provides accommodation for patients for long periods of their lives, we consider more could be done to make bed areas more homely.

There was a garden area to the front of the ward but this required staff support to access it. We were told that costings had been done to make an outdoor enclosed sitting area beside the main day room which would enable patients to access outdoor space themselves. It was not clear if or when this work would be carried out. The Commission would appreciate an update on this issue.

Recommendation 4:

The service should consider how to personalise patients' bedrooms and dormitories to make the environment more homely.

OTHER AREAS:

We heard about the success in this ward of the smoking reduction programme which began over two years ago in preparation for the implementation of the no-smoking policy. We were told that this has led to notable improvements in patients' mental and physical health and their engagement in activities.

Summary of recommendations:

1. The service should consider an alternate, more user-friendly form for gathering patients' views on their care and treatment.
2. The service should review the arrangements for accessing the therapeutic kitchen to ensure maximum benefit of this resource for the patients.
3. The service should explore the opportunity for patients to use their money to employ staff to increase their access to community activities.
4. The service should consider how to personalise patients' bedrooms and dormitories to make the environment more homely.

Service response and action plan

The Commission requires an action plan to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to **Healthcare Improvement Scotland**.

Alison Thomson

Executive Director (Nursing)

ABOUT THE MWC AND OUR LOCAL VISITS

The Commissions 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.

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 and learning disability care
- We follow up on individual cases where we have concerns and 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.

In addition to meeting with people who use the service we speak to staff and visitors. The visit can be announced or unannounced.

Prior to any visit, we look at information that is publically 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 a variety of other sources e.g. 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 and 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 and 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; the frequency of this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

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