mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Ward 3B, Leverndale Hospital, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 03 September 2017

Where we visited

Ward 3B at Leverndale Hospital is a 24 bed ward which, along with South Ward at Dykebar Hospital makes up the adult acute in-patient service for patients (aged 18-65 years) from the Renfrewshire area.

Located in the grounds of Leverndale Hospital, this is one of the original units on the site, providing mixed sex accommodation consisting of three six-bedded dorm-type areas and six single rooms. On the day of our visit, the ward was full, which is routinely the case, and usually there are a number of patients receiving an enhanced level of observation. On the day of our visit there were four patients requiring this level of care.

There are four consultant psychiatrists who cover the various catchment areas and who admit individuals to 3B. A further consultant involved in the Early Intervention for Psychosis service (ESTEEM) also has individuals admitted to the ward, when required. The nursing team establishment has six staff on an early shift, the same number on a late shift and four staff on the night shift, with a skill mix of 50/50 to trained/untrained staff. There is one senior charge nurse and three charge nurses for the ward.

This was an announced visit. We were provided with information about the ward and the services available to individuals by the two charge nurses who were on duty that day.

We last visited these services on 3 February 2016, and made recommendations in relation to the high levels of observation and pressure on beds, the care plans, safety concerns in relation to the potential for substances misuse on the ward, food availability and choices, maintenance and the future plans for the ward.

On this occasion, we visited to give individuals an opportunity to raise any issues with us and to ensure that the care and treatment and facilities are meeting those needs. We also looked at the following:

- Care planning
- Use of legislation
- Physical environment
- Activities

Who we met with

We met with five patients and reviewed eight care plans. There were no carers or family members that wished to speak to us on the day.

In addition to the charge nurses for the ward, we also were able to speak to the occupational therapist (OT) for the unit. There were no other members of the extended multi-disciplinary team available to speak with us on the day of our visit.

Commission visitors

Yvonne Bennett, Social Work Officer

Claire Lamza, Nursing Officer

What people told us and what we found?

Care, treatment, support and participation

Of the five patients we spoke with, their feedback was overwhelmingly positive. They acknowledged that there were issues arising from environmental constraints but were very positive about the staff and the care they receive.

As described above, Leverndale is part of the wider mental health provision for Renfrewshire and some patients explained that they were assessed at Dykebar then transferred to Leverndale. On one occasion, this happened late at night and the individual was only told that they were going to Ward 3B after they had been through the full admission process at Dykebar. The current two site acute in-patient service appears to be a far from ideal situation for patients, and we would ask managers to keep these difficulties under review.

Care and treatment, support and participation

From our discussions with staff, we found them to be motivated and committed to delivering person-centred care. They demonstrated a comprehensive and in-depth knowledge of the individual's circumstances and their needs. Despite the obvious competing demands, staff were observed providing a high level of care and support to a diverse and challenging mix of patients.

There are a range of disciplines providing clinical care for those in Ward 3B. Along with the nursing team and a consultant psychiatrist, we found evidence that individuals have been able to access occupational therapy, psychology, pharmacy, physiotherapy and advocacy.

There was evidence of good physical care for individuals, both in a general sense but in particular where there were identified physical health needs. One patient was awaiting surgery and staff have been monitoring and encouraging the individual to promote their healthcare needs, including a successful smoking cessation programme, ensuring that they are well enough to undertake this surgery.

Also on the day of our visit, we met with some patients who had a diagnosis of emotionally unstable personality disorder (EUPD) but who described different approaches to their in-patient stay. Two patients received planned admissions, which were offered every 12 weeks for an in-patient stay of up to two weeks; others were told that an admission was not helpful. We were told the planned admission response has been an effective solution to what otherwise has been lengthier hospital stays.

We found the documentation in the care plans was fit for purpose and lends itself to a more person-centred/outcomes focussed style.

We also found that there was evidence of regular reviews of the care, however care plans varied in terms of the amount of detail provided, the level of completion in the care plans and the detail in terms of person-centred care.

Recommendation 1:

Managers should develop a more structured approach to care plan audit to ensure they are person centred.

Use of mental health and incapacity legislation

We found that the information about legal status of patients was clearly defined in the care plan documents.

There was evidence of consideration given to an individual's rights and we found the description of how this information was given to patients i.e. 'little and often' helpful as a way to ensuring patients were aware of their rights and were reminded of these rights at appropriate stage of illness and recovery.

Physical Environment

The dormitory bed areas have one shared toilet/shower area and there were issues reported by staff and patients about the frequency with which toilets are blocked. This results in patients having to use main bathrooms on the communal corridors, which may have an impact on privacy and dignity for patients who are on the ward. We were advised that while maintenance response times are usually good, the plumbing does not seem able to cope with the demands.

We were advised that the dormitory accommodation was an issue, patients who come in to the ward are diverse in age and needs and this causes tension at times within these shared facilities.

While there are laundry facilities available, the tumble dryer has been out of order for some time and the washing machine is reported to be regularly out of commission.

There is a new shared therapeutic kitchen facility within the ward which was due for completion in July 2017 but remains unfinished. At the time of our visit, there was no timescale noted for this to be completed.

In the previous service response, we note that a timescale of two to four years was outlined for phase two of the redesign, however there are various aspects of the current physical environment that require prompt action to be taken.

Recommendation 2:

Managers should develop a programme of work, with identified timescales to address the environmental issues.

Activities

We were pleased to find that there was evidence of a range of activities available both in the ward and in the community, ranging from walking groups and out-and-about excursions led by patient interests. On the day of our visit, a photography group had just taken place. While some of these activities are identified on an activity board in the ward, some are unscheduled and impromptu.

There was a good programme of activities available Monday to Friday and it was evident that nursing staff are adding to the scheduled activities outwith these times, with art and craft activities, which they have devised and facilitate themselves.

When we spoke to the OT, we were made aware that with the move from Dykebar, the OT and physiotherapy facilities are now accommodated in the ward. This has been seen as a successful model for ensuring integrated and accessible services. A combination of group activities and individual interventions has been further supplemented by the opportunity for individuals to simply ‘drop-in’ and see what was going on and participate if they felt able to.

When the new shared therapeutic kitchen facility is available, it is anticipated that there will be opportunities for individuals to participate in breakfast and lunch clubs. Until then staff are looking at alternative means of providing this, i.e. using local café facilities. Formal kitchen assessments that require to be carried out are done so in Dykebar, which requires travel time and planning. Completion of the kitchen will increase activities, but at the moment, these opportunities are reduced and restricted.

The activities on the ward are further supplemented by the ESTEEM team who work with in-patients on the first presentation. The staff from this service work with those individuals who are appropriate to the ESTEEM service, by coming to the ward and providing an outreach service that links in with community groups to support and facilitate a smoother return to the local area.

There was also evidence of good links with the local advocacy project, whose presence and activity within the ward was evident.

Summary of recommendations

1. Managers should develop a more structured approach to care plan audit to ensure they are person centred.

2. Managers should develop a programme of work, with identified timescales to address the environmental issues.

Service response to recommendations

The Commission requires a response 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.

Mike Diamond
Executive Director (social work)

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 MWC 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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