Mental Welfare Commission for Scotland

Report on announced visit to: Wards 4A, 4B, 3A & IPCU Leverndale Hospital, 510 Crookston Road, Glasgow, G53 7TU

Date of visit: 29 & 30 January 2019

Where we visited

We visited the adult acute mental health admission wards 4A, 4B, 3A, and the Intensive Psychiatric Care Unit (IPCU) at Leverndale Hospital over two days. These wards are all primarily for patients aged 18 to 65 from South Glasgow.

The adult acute admission wards are 24-bed, mixed-sex wards. 4A and 4B are newer purpose-built wards, where all patients have single en-suite rooms. Ward 3A is an older-style ward, with a mixture of shared dormitories and individual side rooms.

The IPCU is a 12-bed unit for patients requiring intensive treatment and intervention. This ward is also a mixed-sex facility, with a mix of single rooms and small dormitory accommodation. Patients tend to be predominantly male, and when we visited there were no female patients. An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation. IPCUs generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often distressed patients.

We last visited the adult acute admission wards on 8 and 9 November 2017, and made recommendations that care plan documentation should be reviewed to ensure that the specific needs of individual patients are met.

We last visited the IPCU on 8 February 2018, where we expressed concern regarding several patients who had been in the unit for 12 months or more.

This was one of our regular visits to adult wards. We wanted to meet with patients, follow up on our previous recommendations, and look at general issues important for patient care.

Who we met with

We met with and/or reviewed the care and treatment of 27 patients during the visit. We also spoke with one relative.

In addition we spoke with the charge nurses from each ward, occupational therapy, and several members of clinical staff.

Commission visitors

Paul Noyes, Social Work Officer

Mary Leroy, Nursing Officer

Mike Diamond, Executive Director (Social Work)

Mary Hattie, Nursing Officer

Anne Buchanan, Nursing Officer

Kathleen Taylor, Engagement & Participation Officer

What people told us and what we found

Care, treatment, support and participation

Given the different settings and functions of the wards, patient experience between the four wards is quite different, but generally patients were positive about their care.

All the wards were at full capacity when we visited, and it was evident that the bed-management of patients is challenging. In the acute adult wards patients were under the care of between three and six consultant psychiatrists, the logistics of which can be quite difficult to manage. We heard that, generally, staffing levels are good with no difficulties in recruitment. Though staff were very busy, the patients we spoke to said staff were very approachable and helpful. We found the charge nurses and staff we spoke to were very motivated, and enthusiastic to provide good care for their patients.

All patients had a specific nurse allocated to their care, which promotes continuity and enhances therapeutic relationships with both patients and their families. One-to-one meetings with patients were well documented, as was contact with their relatives. It was also clear that there had been discussion with patients with regard to information sharing with their families.

We heard of an example of good patient involvement from a patient on Ward 3A. The patient explained they had been able to meet with the pharmacist to discuss their anti-depressant treatment, and effectively chose the anti-depressant most suitable for them.

The senior charge nurses from all the adult acute wards reported their wards always being full to capacity. Ward 3A in particular reported often having patients boarding with them from the other two adult acute wards. There were five patients who would have normally been in Wards 4A and 4B on this ward during our visit. This can cause disruption for patients having to change wards, and makes the medical management of patients by their consultants more difficult. There were one or two patients on an enhanced level of observation on each of the adult acute wards, which is not unusual on such wards.

The IPCU beds were also full on the day of our visit. All of the patients were male. We highlighted concerns on our last visit with regard to a number of patients having spent more than a year in the ward. The difficulty of moving patients on to more appropriate specialist resources is still very much an issue, and we spoke with several of the same patients we saw on our last visit. We noted, however, that the issue of moving on was being addressed in care planning meetings, and move-on options were being considered.

Recommendation 1:

Managers to continue to address the needs of all patients who have been in the IPCU for 12 months or more, to ensure there are no deficiencies in care relating to lack of appropriate provision, and address these deficiencies.

Patient records included evidence of weekly multidisciplinary team (MDT) meetings to discuss patient progress and care on all the wards. We found MDT notes to be detailed and clear, though they sometimes did not record who had attended the meeting. This inconsistency should be improved. We noted good patient and carer involvement in treatment and care planning. Patients generally attended their MDT meetings or, if they preferred, are spoken with after the meeting. Psychology have a regular input to the MDT and patients have good access to psychology. There is also a dialectical behaviour therapy (DBT) team based at Leverndale, providing services to patients diagnosed with personality disorder.

Patients had good input from occupational therapy (OT), with cover being provided across the wards. We heard about a health promotion group for patients being run in conjunction with physiotherapy, focusing on sleep, managing stress, and exercise. This was a good example of joint working.

Where patients had completed advance statements these were highlighted, and easily found in patient notes.

Patients' physical healthcare needs appeared to be well met, with referral to specialist services if required.

Staff informed us that advocacy is readily available to patients on the wards on an as required basis. There were no members of advocacy staff present on the ward on the day of our visit.

Our last visit to the acute wards made recommendations that care plan documentation should be reviewed, to ensure that the specific needs of individual patients are met. We found that the care plans for patients on Ward 4A had taken account of this recommendation, with personalised plans addressing specific patient needs. Such plans were well reviewed. These improvements were not evident on Wards 4B and 3A, where care planning documentation was still generic, pre-printed, and failing to address the individual needs of patients.

The care plans for IPCU patients were personalised and regularly reviewed, along with comprehensive assessments of risk.

Recommendation 2:

Managers should ensure that care planning documentation is improved across all three acute adult wards to ensure that care plans address the specific needs of individual patients.

Use of mental health and incapacity legislation

On the acute adult wards, around half of the patients were detained patients. On the IPCU ward all patients were detained patients, as is consistent with this facility. All of the patients we interviewed were clear about their status, as were the staff.

For detained patients, we generally found the legal paperwork to be in order and accessible, either within patient care files or on the electronic data system. We also established that all the detained patients had consent to treatment certificates (T2) and certificate authorising treatment (T3) forms where required.

On reviewing these forms we noted that, for a small number of patients, there were medications being given but not listed on their T2/T3 forms. This was raised on the day.

On the IPCU ward we became aware, through speaking to patients and reviewing notes, that four patients were receiving ‘as required’ medication, to be administered intramuscularly (IM) for agitation on T2 forms. This indicates that they are consenting to IM medication for agitation at the time this is felt to be urgently necessary.

Our view is that a patient is unlikely to be consenting to IM medication in such circumstances, and in one case it was evident the patient was not consenting. It would appear that, in such cases, treatment is outwith the authority of the Mental Health Act. We consider it is best practice for a medical review by a Commission designated medical practitioner (DMP) to be arranged, if circumstances arise where intramuscular medication may be required.

Recommendation 3:

Managers should ensure intramuscular “if required” psychotropic medication is not included on T2 forms, other than in exceptional well-documented circumstances where a patient wishes to give enduring consent to this treatment.

Rights and restrictions

On the acute adult wards, patients who were not detained were observed generally coming and going freely, with open access to the garden areas.

The IPCU, like other similar wards, is a locked ward for reasons of patient safety and risk factors. Many of the patients, however, had agreed plans allowing for short spells of suspension of their detention, to allow for periods of escorted or unescorted time out of the ward to aid in their recovery.

For patients on enhanced observation at the time of our visits, we noted that staff were trying to keep this observation as unobtrusive as possible, and to use this time for therapeutic interaction.

Patients we spoke to appeared to be clear about their status but we are aware that informal patients can often be unsure as to what they can and can't do. 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/media/369925/human_rights_in_mental_health_services.pdf

Activity and occupation

There are two patient activity co-ordinators (PAC nurses) who provide input to the three adult acute wards. Nurses also help provide activities for patients, particularly in the evenings and at weekends. In addition, patients have access to the recreational therapy facility within the hospital grounds.

We noted there was a good range of programmed activity, including groups for walking, relaxation, cookery, money matters, exercise, and recovery. Patients appreciated and enjoyed the various activities available to them. We noted on Ward 4B that patients had an individualised activity planner in their rooms.

The wards all have dedicated occupational therapists and occupational therapy technicians, providing one-to-one interventions and additional group activity.

We have previously commented positively on the activity nurse input in the IPCU, with an open-door policy for activity based around a well-provisioned activity room. We heard that this nurse has recently retired and this post is currently unfilled. Nurses and the OTs are currently filling this role, but this provision is currently greatly missed. We would expect managers to address any issues of deficiency of activity in the IPCU, if this becomes an issue for patients.

The physical environment

Wards 4A & 4B are newer-style wards, where all patients have en-suite single rooms. Ward 3A and the IPCU are older wards with a mixture of single rooms and dormitory (four to five patients per dormitory) accommodation. In the IPCU the bedroom area is locked off from the day area for much of the day. This is primarily to encourage patients to engage with staff and therapeutic interventions. Patients could still access their bedrooms and belongings if they needed to.

Several patients from Ward 3A said not having their own room to "retreat" to can be stressful at times, particularly if other patients are very unwell and distressed.

The acute adult wards have a shared dining area/visiting space. This means meals have to take place in two separate sittings. The visiting area can also get busy at times and is not particularly private. We heard from patients that staff try to be flexible, and some of the smaller rooms on the ward can also be used for visitors.

All the wards have easy access to garden areas. The fact the acute ward gardens are not enclosed does present difficulties in the management of detained patients, and can result in an increase in the need for enhanced observations. Several of the garden areas were untidy and this environment could be improved.

Summary of recommendations

1. Managers to continue to address the needs of all patients who have been in the IPCU for 12 months or more, to ensure there are no deficiencies in care relating to lack of appropriate provision, and address these deficiencies.

2. Managers should ensure that care planning documentation is improved across all three acute adult wards, to ensure that care plans address the specific needs of individual patients.

3. Managers should ensure Intramuscular “if required” psychotropic medication is not included on T2 forms, other than in exceptional well-documented circumstances where a patient wishes to give enduring consent to this treatment.

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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