

**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Wards 5, 6, Boulevard, Bute and Campsie, Leverndale Hospital, 510 Crookston Road, Glasgow G53 7TU.

**Date of visit:** 13 and 14 December 2017

## **Where we visited**

We visited wards 5, 6, Boulevard, Bute and Campsie wards; these five wards make up the low secure forensic service for Greater Glasgow and Clyde and are based at Leverndale Hospital.

Wards 5 and 6 each provide low secure facilities for 15 men. Bute ward provides a female low security provision for five women. Boulevard ward is a male, nine-bedded, 'pre-discharge' ward and Campsie ward is nine-bedded, male, low security ward for forensic patients with a learning disability.

We last visited this service on 1 and 2 November 2016 as part of our national themed visits to low security forensic wards in Scotland.

There were no specific recommendations from these visits but we commented on the fact that all the patients on these wards had been individually designated as specified persons in relation to safety and security provisions.

Our main reason for visiting on this occasion was as part of our regular visits to adult forensic wards, where patients are subject to restrictions on their liberty. We wanted to follow up on our previous visits and to look at general issues important for patient care:

- care, treatment, support and participation
- use of mental health and incapacity legislation
- rights and restrictions
- activity and occupation
- the physical environment.

## **Who we met with**

We met with and/or reviewed the care and treatment of 23 patients across the five wards.

No relatives requested an interview or were present during the visit.

We also spoke with the senior charge nurses on each ward, several members of nursing staff on the wards and met with the forensic service managers.

In addition, we met with advocacy workers from Circles Network advocacy project.

## **Commission visitors**

Paul Noyes, Social Work Officer

Dr Ritchie Scott, Medical Officer

Mary Leroy, Nursing Officer

Kathleen Taylor, Engagement & Participation Officer

Yvonne Bennett, Social Work Officer

Gordon Johnston (observer), MWC Board Member

## **What people told us and what we found**

### **Care, treatment, support and participation**

From speaking with staff and patients on all these wards, it was evident that there is a very considerable pressure on low security beds. Beds are always occupied and there is a considerable waiting list for admissions.

The majority of patients in these wards have an offending history and are 'restricted patients' requiring Scottish Ministers' authorisation and comprehensive risk assessments in relation to leaving the wards. These processes are often lengthy and can cause frustration for patients awaiting permissions. There were new patients on wards 5 and 6 who expressed their considerable frustration at not being able to leave the ward, given they had been able to do so when accommodated in medium security. This issue is one which the Commission has recently raised with the Scottish Government. The Commission made a recommendation about this.

Patients on all the wards were very positive about their care and treatment and spoke very favourably about their relationships with nursing staff and doctors. We were able to speak with patients on all five wards and patient comments included 'the staff are excellent', 'fabulous nurses' and 'staff are approachable and very fair'. Patients said staff treated them with dignity and respect in all interactions.

It was clear from talking to patients and from looking at their notes that they are involved in their care. There are weekly multidisciplinary meetings on all the wards to discuss, and review patient care and progress. As well as good medical and nursing input, we also noted good multidisciplinary involvement from psychology, occupational therapy, speech and language therapy, pharmacy and physiotherapy when required. There was evidence of good physical health care input with annual patient health checks and appropriate health screening, particularly among the female patients. The self-medication protocol enabling patients to take responsibility for their own medication was also noted as good practice.

Patient care plans were very full, detailed and reflected the individual needs of each patient. All the patients on these wards are managed on Care Programme Approach (CPA) which gives a very clear focus to their care management. The CPA paperwork was clear with cases all being regularly reviewed with good evidence of multidisciplinary input.

Patients on these wards receive a high level of psychology input. The risk assessment process is led by psychology, and psychologists also provide one-to-one interventions with most patients. A number of recovery based groups such as 'coping in the community', 'planning for the future' and a budgeting group are psychology led. They also run therapeutic relapse prevention groups in relation to drugs and alcohol, these interventions were well documented.

Boulevard and Bute wards function within a home-style model of care which encourages patients to further develop skills. They work alongside staff in the upkeep of the ward, participating in menu planning, shopping, cooking and domestic chores to develop their skills for moving into the community. Patients seemed to appreciate this model of care and again this is an example of good practice.

We noted considerable efforts to encourage and maintain contact with carers and families and we saw documentation of contact with carers evidenced in care records. The wards are working with a focus on 'triangle of care standards' in relation to carer involvement. Maintaining contact with carers and families can be a particular difficulty for forensic patients and we were pleased to see this factor being addressed.

### **Use of mental health and incapacity legislation**

Due to the restrictions on patients and the fact the wards are locked, we would expect that all patients on these wards should be detained patients. This was the case for all the patients at the time of our visit.

For the patients whose notes we reviewed, we found the appropriate detention paperwork and the patients we interviewed were clear about their status, as were the staff. Most of the patients had spent many years in hospital and were aware of their rights in relation to their detention and had legal representatives.

The patients all had access to advocacy and the wards have very good and regular advocacy input from Circles Network advocacy, a specialist forensic advocacy service. As well as individual work, they run meetings on the wards to help patients with collective issues.

We also established that most of the detained patients had consent to treatment certificates (T2) and certificate authorising treatment (T3) forms where required. Some T3 forms on Campsie Ward were out of date and requiring review. We also noted that on Campsie Ward, where many of the patients lacked capacity, a number of patients (who clearly had no capacity to make decisions) had no certificate of incapacity (s47) certificates authorising medical treatment for physical issues.

### **Recommendation 1:**

Managers should review T2 and T3 certificates and the need for s47 certificates particularly on Campsie Ward.

When reviewing patient notes we noted that there were a number of patients whose named persons in relation to their detention were 'default' named persons. Recent changes in the Mental Health (Scotland) Act 2015 are phasing out default named persons (by 30<sup>th</sup> June 2018). Patients who still have default named persons require to be appraised of this situation, and nominate a named person if they so wish and are able to do so.

### **Recommendation 2:**

Managers should address the recent changes in legislation with patients with named persons by default.

### **Rights and restrictions**

As has been the case in previous visits, all patients on these ward were individually designated as 'specified persons' in relation to safety and security provisions. This has been raised with managers on previous visits and we have been assured that each patient's specification is reviewed on a three-monthly basis in line with their individual management plans. Following specification, patients are informed in writing of their right to appeal the situation. Patients generally seemed accepting of the situation as part of ward security.

Our expectation is that use of specified persons provisions should be based on individual risk not a blanket policy. Staff were, however, very clear that they felt having patients individually designated as specified persons was necessary for the protection of patients and staff in these wards.

The wards (and hospital) are non-smoking areas, patients are offered smoking cessation support if requested. Patients able to leave the grounds can smoke if they wish away from the hospital. We were informed that from 1 November 2017 patients will have a 12-week programme of smoking cessation support, and after that time nicotine replacement will stop. There is an issue at present with many patients requesting nicotine replacement but still smoking when off the ward. The initial 12-week period will end on 24 January 2018 when the situation is likely to take effect with patients who had been receiving nicotine replacement.

### **Activity and occupation**

Patients we reviewed had clear and very structured activity plans / weekly planners. They were in accessible formats specific to the individual patient's capacity and understanding. We were pleased to see the level of activity that was available and that this activity was very much recovery focused.

We also noted a high level of occupational therapy (OT) input with dedicated OT staff for each ward. There is a recreational therapy (RT) unit and a gardening project (Acorn) in the grounds of the hospital which are well used and good links with further education and employment projects.

On ward groups included art, newspaper group, jewellery making, cooking and a wide range of activities were listed (particularly for patients on Campsie) including golf, football, gym, horse riding and Tai Chi all very much based on personal choice.

Many of the patients require to be escorted when away from the ward, which requires a lot of staff time. In past visits to these wards, patients have raised issues about activities being cancelled if there have not been staff available. This was not the case on this visit and the wards had full staffing complements.

For patients, particularly new patients with no time off the ward, there was less to do in terms of activity and these patients rely more 'on ward activities'. This can be a frustrating and difficult time while awaiting permissions from Scottish Ministers.

### **The physical environment**

The general physical environment for these wards is good with the wards either having been built or adapted for purpose.

Wards 5, 6, and Boulevard all have single rooms with en-suite facilities. Bute and Campsie have single rooms but are not en-suite. All wards are bright, well-furnished and freshly decorated. All wards have access to enclosed garden areas.

In terms of environment, our only issue of concern is on wards 5 and 6 in relation to patients' ability to make private telephone calls. Several patients raised the issue of the patient phone being in a very public open ward area. Not only is it not private, it can also be noisy and not conducive to keeping in contact with family, partners and children. This is a particular issue for patients who have no unescorted leave or ability to have use of their own phones.

### **Recommendation 3:**

Managers should address patient concerns about the location of the patient phone and lack of privacy for patients.

### **Any other comments**

We noted that despite patients generally having been in hospital for many years, most did not have advance statements, and we saw no evidence that advance statements were being actively promoted on the wards. The Commission has recently produced guidance and information to encourage use of Advance Statements - <http://www.mwcscot.org.uk/get-help/getting-treatment/advance-statements>

**Recommendation 4:**

Managers should promote the making of advance statements.

**Summary of recommendations**

1. Managers should review T2 and T3 certificates and the need for s47 certificates particularly on Campsie Ward.
2. Managers should address the recent changes in legislation with patients with named persons by default.
3. Managers should address patient concerns about the location of the patient phone and lack of privacy for patients.
4. Managers should promote the making of advance statements.

**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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