Mental Welfare Commission for Scotland

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

Date of visit: 2 December 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.

On the day of our visit there were no vacant beds.

The ward is a mixed-sex facility, split to accommodate a maximum of three female in single rooms, with nine to 12 male beds provided by a mix of single rooms and small dormitories. At the time of this visit, there were nine men and three women in the IPCU.

We last visited in January 2024 on an unannounced visit and made one recommendation regarding the planned programme of work that was due and which would ensure that the IPCU provided a conducive setting for all individuals. The response we received from the service was that managers had received endorsement to complete the improvement works to the IPCU.

On the day of this announced visit, we wanted to meet with as many individuals and their families on the ward as possible, to hear about their experiences and the views they had about the care and treatment delivered by the service.

Who we met with

We met with nine individuals and reviewed the care notes of ten people. We also met with two relatives.

We spoke with the service manager, the operational nurse manager, the senior charge nurse, the deputy charge nurses, the consultant psychiatrist, the specialty doctor, the psychologist, the occupational therapist, the therapeutic activity nurse and nursing staff throughout the day.

Commission visitors

Justin McNicholl, social work officer

Paul Macquire, nursing officer

Graham Morgan, engagement and participation officer

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included their legal status, contact with staff, individual participation in their care and treatment, activities available to them and their views about the environment. We were also keen to hear from individuals who had been in the ward for over one year and those who had been subject to restrictive measures.

We heard a variety of views from the individuals that we spoke with, some were very positive regarding the care they were receiving from staff. We heard comments such as “it’s really been fantastic here, the staff couldn’t have been better", “the staff are helpful”, “approachable” and “the staff are much nicer here than the other wards in Leverndale”. There were positive comments from individuals who reported that they “get on well" with psychiatry staff, who they reported were “fair” and “easy to access”.

We heard comments that were less positive; these included, “they sit in the nurses room and ignore us”, “I’ve witnessed the staff restraining a lady, it was really unpleasant” and “the staff pretend to be nice but they are not”. We followed up on these comments with the nursing staff and were reassured that steps were being taken to address the concerns and views raised with us.

The majority of individuals and their relatives praised the ease of access to the multi-disciplinary team (MDT) and the ability to have one-to-one discussions with their named psychiatrist.

The staff members we spoke with knew the individual’s circumstances well and were able to comment on the care that was being delivered, where restraint had been used, restrictions, risks and discharge plans. This was further evidenced in the interactions we observed and the detailed daily notes we read.

We met with the new psychologist for the ward who was covering the service and spoke of being impressed by how well the MDT worked together to address case formulations, undertake reflective practice sessions and prioritise discharge planning. There was particular praise for the role of therapeutic activity nurse who was noted to be “engaging”, “valuable” and “someone who the entire nursing team valued” as this role has helped to ensure groups could take place and fostered a positive culture throughout the ward.

Relatives and carers had been made aware of our visit in advance, either via telephone calls, posters placed in the hospital or through the staff prompts. On the day of the visit, were able to meet with two relatives who spoke to us about their experiences. One commented, “the staff are absolutely amazing, this was my son’s first admission and I had so many questions. They answered them all and have been there for me when I’ve struggled with any issue”. Another stated “I am the named

person. Every time I want to obtain information the staff are always seeking his consent before sharing information. I find this frustrating, however the communication has improved over time." Both relatives stressed the ease of access to staff and reported this as one of the main positives of the ward when trying to support their relatives.

Individuals told us about their current accommodation in the ward and how, in particular, they did not like having to share a dormitory with another person. We heard "the building is not very nice", "the floor in the shower room is uneven and I nearly fell", "I want the place shut down" and "I don't have any privacy at all, it's horrible". These views were similar to those from our previous visits and continue to cause the Commission concern that the previous recommendations have yet to addressed by the health board, despite the fact we have been provided with repeated assurance that changes to the environment would be addressed as a priority.

Several individuals gave us their views of the food; "the rice was hard", "the food is horrible, I don't feel satisfied with the meals" and "I have stopped eating as much due to what is being served". We heard that the selection of halal meal options was "poor".

Managers told us that they continued to have regular meetings to discuss bed pressures, delayed discharges, individual admissions, along with staffing numbers required to ensure the safe delivery of care. We were advised that two individuals in the ward has their discharge from the service delayed, and that this had been recorded as such.

The service manager told us about continued proactive efforts to recruit staff to vacant posts and it was positive to hear that they had recently been able to employ staff through the graduate recruitment process.

Care, treatment, support, and participation

Care records

Information on individual's care and treatment was held on the electronic system, EMIS. We found this easy to navigate, and it allowed professionals to record their clinical contact in one place.

Daily care records were detailed, with clear and consistent recording of the individual's mental health presentation throughout the day and night. There was evidence of one-to-one sessions occurring between individuals and nursing staff.

We found completed Getting to Know Me (GTKM) documentation in some of the files we reviewed and this was used to inform care plans. GTKM is a document that collates information on an individual's needs, likes and dislikes, personal preferences

and background to enable staff to understand what was important to the individual and how best to provide person-centred care while they were in hospital.

Nursing care plans
Nursing care plans are a tool that set out detailed approaches of what nursing care and interventions will be delivered; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. We found that individuals in the hospital had care and treatment plans in place to support admission goals and outcomes. These were stored on the EMIS electronic recording system using a Microsoft word template which was then added as document to the system. Once uploaded to EMIS, the care plans could not be edited to reflect changes in person's presentation. Where needs were identified in care plans reviews, a completely new care plan had to be uploaded every time changes were required.

Recommendation 1:
The system for electronic recording of care plans should be reviewed to ensure it is fit for purpose, enabling staff to update care plans to reflect changes identified in reviews that maintains a live document which reflects the progress and supports the delivery of person-centred care.

The person-centred detail in care plans was sufficient to provide a picture of the individuals needs and preferences, although some contained broad statements without clarifying what specific techniques were used for the individual concerned. Some individuals appeared to be aware of their care plans and how they related to the care being delivered while others were too unwell to recall aspects of their care and treatment.

Care plans addressed the risks identified in the CRAFT risk assessments, which were regularly updated. Where physical health needs had been identified, these were addressed.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

Participation
There was clear evidence that the therapeutic activity nurse for the ward regularly met with the patients on each ward. This ensured that requests for activities were prioritised and addressed. We heard from senior managers that steps continue to be made to maintain standards in the ward and in speaking with individuals they were aware when steps had been taken to address any issues raised.

Similar to our last visit, we found individual could easily access advocacy and this provided them the opportunity to feedback on any issues, themes or concerns that were arising in the ward on a daily or weekly basis.

Multidisciplinary team (MDT)
There was a broad range of staff providing input to the IPCU. The ward has one consultant psychiatrist, one doctor with a specific remit for the ward and one junior doctor.

The MDT notes included input from psychology, pharmacy, occupational therapy staff and the activity co-ordinator. For individuals who required additional support from allied health professionals, referrals were made to specific services including physiotherapy, speech and language therapy and dietetics.

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. All MDTs included action points noting who was responsible for taking the specific matter forward. We found good evidence of the recorded views of the patient and their families. We found proactive steps had been taken by the ward staff in taking the opportunity to speak with families and in maintaining regular contact on a weekly basis. We heard that social work referrals were made early in the admission process, however there could be delays with the allocation from Glasgow City council due to workload pressures.

We heard from managers that due to the demands placed on hospital beds across NHS Greater Glasgow and Clyde (NHSGGC), the ward had to discharge individuals directly from the IPCU. It was acknowledged by various staff that we spoke to that this practice was not ideal as it had a direct impact on the ability to provide safe, therapeutic rehabilitation for those who required it.

Due to this challenging set of circumstances, the MDT had adapted their practice to work earlier with individuals on their recovery journey and to identify steps that could be taken in the community that would support the person to undertake better access to community activities.

We met with the occupational therapist who spoke of the MDT becoming “more skilled around discharge”. There was no data supplied by the ward staff to the Commission visitors on whether this had resulted in positive outcomes for individuals. We will continue to monitor this matter to approach to discharges from the service to see if there is any impact on individuals over thus coming year due to this change in practice.

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.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found that this was recorded.

Rights and restrictions

The IPCU operates a locked door policy commensurate with the level 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.

Individuals could use the garden area of the ward to ensure they had access to fresh air and the ability to have time out with the ward environment and for exercise, if they so wished.

We heard from staff that the promotion of, and referrals to advocacy for individuals were prioritised by the ward. We found good evidence of this, with individuals advising us that they could easily access advocacy and were advised of their rights.

We heard from individuals that they were given documents and helpful information leaflets on the Mental Health Act which helped them to understand their rights.

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 person is specified in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit, people were subject to these measures.

We found specified person paperwork in place, however not all patients had a reasoned opinion form attached to the order. We had a further discussion with the consultant psychiatrist and specialty doctor about this gap in recording. They confirmed that at present NHSGCC do not have a template in place to address this gap in reasoned opinions although agreed to take steps to address this in the coming weeks.

The Commission has published a good practice guide in relation to specified person which nursing and medical staff may find helpful when considering restrictions: specified_persons_guidance_2015.pdf

Recommendation 2:
Managers should ensure a reasoned opinion is provided for all restrictions applied to individuals specified under the Mental Health Act.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We found one advance statement on file.

We were pleased to hear from staff that in keeping with previous visits in 2023 and 2024, that there has been a significant decrease in the use of the de-escalation room and incidences of violence. Staff reported that the de-escalation room was being utilised by individuals in a different way and some patients used it as a way to manage their distress.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

Providing activities for individuals in IPCU settings can be an issue due to the level of restrictions people may need to have in place. We were pleased to hear of the ongoing positive work of the therapeutic activity nurse (TAN) to mitigate this. This role has ensured that there is an opportunity to offer activities to all individuals on a one-to-one basis or in small groups. During our visit we were able to observe a full list of daily activities that were displayed on the wall of the ward. We met with the TAN to discuss their input and flexible approach to engage with as many people as possible depending upon their willingness to do so.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

The occupational therapy staff worked with individuals on or off the unit, depending on their activity planner and /or suspension plans approved by Scottish Government, which permitted time off the ward.

We found clear evidence of each individual's participation in activities 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 those that we spoke with. We heard from managers of the success of this year's fifth Meander for Mental Health event which allowed those with grounds access to participate in September.

We heard comments from individuals that there was "plenty to do" which included reading, watching movies, karaoke, smoothie making, exercise groups, gym access and artwork. We heard from two individuals that "there was nothing to do" and they would like a "access to video games".

The physical environment

The physical environment of the ward remains largely unchanged since our last visit.

The ward continues to be stark and there were signs of general wear and tear throughout all areas of the ward. The basic decor of the ward did not provide a positive experience for individuals and the use of dormitories made privacy and promoting a good sleep pattern problematic.

The lack of en-suite facilities continued to be raised by those that we spoke with who described to us that they "never felt comfortable" or "safe" due to the ward layout. The aging facilities remain far from ideal for maximising patient care.

The Barron Report: Independent Forensic Mental Health Review was commissioned by the Scottish Government and published in 2021. This report was particularly critical of the current dormitory style IPCUs in Scotland. The report made specific recommendations regarding the physical environment of services where forensic patients may require care and treatment and for health boards to address these issues.

In our previous visit reports, we highlighted our concerns and made recommendations about the physical environment in the IPCU. We have continued to raise our concerns with senior managers in GCCNHS but to date, nothing has changed.

We are aware that there has been ongoing discussions with senior managers regarding the environment and that since our second last visit, there had been capital funding to address this issue.

We agree with the views of the Barron Report, in that individuals who require to be admitted to an IPCU should not have to share accommodation and should have their care, treatment and support provided in a welcoming and therapeutic environment.

We therefore urge senior managers of NHSGGC to consider this when they are making future improvements. We will continue to request an update from senior manager of NHSGCC on the IPCU accommodation.

Recommendation 3:
Managers should seek to progress the work to ensure that the IPCU environment is safe, welcoming, therapeutic and fit for purpose.

Summary of recommendations

Recommendation 1:
The system for electronic recording of care plans should be reviewed to ensure it is fit for purpose, enabling staff to update care plans to reflect changes identified in reviews that maintains a live document which reflects the progress and supports the delivery of person-centred care

Recommendation 2:
Managers should ensure a reasoned opinion is provided for all restrictions applied to individuals specified under the Mental Health Act.

Recommendation 3:
Managers should seek to progress the work to ensure that the IPCU environment is safe, welcoming, therapeutic and fit for purpose.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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

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 an individual's care, treatment, and support are 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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