Mental Welfare Commission for Scotland

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

Date of visit: 11 December 2024

Where we visited

The rehabilitation ward is an 11-bedded, mixed-sex ward providing intensive rehabilitation for adults with severe and enduring mental illness. Referrals generally come from acute in-patient wards. People can spend several years in the ward to allow initial recovery from an episode of mental ill health and subsequent therapeutic work to regain skills of daily living and progress to independent living in the community.

On the day of our visit, there were 11 people in the ward and one person waiting for admission from a medium stay rehabilitation ward. Two people were felt to be ready to move on from the ward and there was ongoing work to ensure that their complex care and treatment needs would be met. No one in the ward was considered to be a delayed discharge (when someone is ready to leave hospital but is unable to do so due to a lack of community provision), although we were told by the team that it can take some time to identify appropriate accommodation and support for individuals in the community due to their complex care needs.

We last visited this service in October 2022 on an announced visit and made three recommendations . These were about ensuring annual health checks for people in the ward, review of the need for therapeutic activity nurse provision and the need to upgrade the ward environment. In response to our recommendations, we were told that nursing and medical staff would ensure that annual health checks are carried out for people in the ward. We were told that the service manager did not consider that a therapeutic activity nurse was required in the rehabilitation ward as there were a range of other professionals providing specialist therapeutic activity. With regards to the recommendation to upgrade the ward environment we were told that there was a service wide review of rehabilitation services underway which would include the physical environment.

On the day of this visit, we wanted to follow up on the previous recommendations and hear from people about their experience of care and treatment within the service.

Who we met with

We met with six people in person on the day of our visit and reviewed their care records. We spoke with one relative the following day.

We spoke with the service manager, the senior charge nurse and members of the multi-disciplinary team including medical, nursing, occupational therapy and psychology staff.

Commission visitors

Sheena Jones, consultant psychiatrist

Paul Macquire, nursing officer

What people told us and what we found

As our visit was announced people and their families knew that we were coming and many of the people in the ward were keen to speak to us. The poster that we had sent announcing our visit was evident on one of the notice boards in the entrance to the ward. Whilst relatives were not able to attend the ward on the day, we were provided with their contact details and at the time of writing this report had spoken with one relative.

We heard overwhelmingly positive feedback about the care and treatment people received in the ward and about the staff in the multidisciplinary team.

People told us that “staff are very supportive”, that they are “nice and friendly” and that they go “out of their way to be caring”. People said that this was the “best ward in the hospital” and the “best ward (they had) been in”.

One person told us that they felt safe in the ward and that this helped them to sleep. They also said that the staff were “wonderful”. Another told us that “one of the things I love about being here, is that there are always things to do”.

People said that whenever they have raised a concern with staff or had a problem with their physical health, it gets dealt with, “nothing gets left”. We heard that people felt they could speak to the multidisciplinary staff and that they were able to meet regularly with their doctor to talk about their treatment.

One relative spoke about the staff going out of their way to help their family member at the time that their parent had died. The person had also told us how much they valued this.

We heard from the multidisciplinary team about the service development work that they had undertaken to gain accreditation through the Royal College of Psychiatrists. This has included ensuring that people are involved in meetings about their care and treatment and a programme of specialist training for the rehabilitation team.

We were told by senior staff that there had been no significant adverse events since our last visit and no formal complaints.

Care, treatment, support, and participation

On the day of our visit the ward was quiet and calm. We saw people engaging with staff in a relaxed manner. It was evident that the care team knew the people in the ward well and provided us with detailed information about their care and treatment, with a real understanding of each person and their individualised needs. We also saw nursing staff supporting individuals to reduce their anxiety when they were meeting with us.

The ward meeting was happening on the morning of our visit which meant that we had the opportunity to meet with various members of the multidisciplinary team.

We heard that some of the nursing staff were trained in Behavioural Family Therapy (BFT) and would work with individuals and their families when their mental health and recovery allows. We were given information about the progress many people in the ward had made in BFT work.

We heard that in the majority of cases, people's families were regularly involved in care and treatment. While it could be difficult for families to regularly attend ward meetings, the communication with them through the BFT approach and in family meetings was felt to be good.

In addition to the BFT work we heard from the psychology team that they offer Social Cognition Interaction Training (SCIT). This is an evidence-based therapy for people with psychosis that involves 20 hour-long sessions for each person on a weekly basis. There were other groups provided by psychology, psychiatry and the multidisciplinary team that included a recovery group, a multidisciplinary health and well-being group and a cognitive remediation programme.

People could also access individual therapies, and we heard recent examples of cognitive behaviour therapy for people with psychosis and work on trauma and social anxiety.

It was evident that the service was taking an individualised and inclusive approach to care and treatment for individuals in the service with involvement of all relevant professionals in the multidisciplinary team.

Care records

We reviewed people's care records on the electronic record system, EMIS. We looked at the electronic medication prescribing system, HEPMA and reviewed information relating to the mental health act in paper files.

We found a wide range of information in the electronic care record for each person.

Care records included information about each person such as 'Getting to Know Me', 'My view', and 'What matters to me' documents.

We could see a range of assessments undertaken by various members of the multidisciplinary team which were individualised to each person's specific needs and which covered, for example, physical health, mental health, side effects of medication, finances, activities of daily living and ability to engage in individual and group therapy.

Care plans also covered a wide range of issues, individualised to each person, and included physical health, mental & psychological health, family therapy, social needs, legal aspects of care and spiritual needs. We could see that care plans were often reviewed in collaboration with people and nursing staff and that the views of people, their families and carers formed the basis of many of the care plans. We could see that the care plans had clear outcomes linked with a range of activities and therapeutic work and that they were regularly reviewed and updated.

The electronic care records were updated each day by nursing staff and included information about the person's mental health, their activities that day and other key information. The updates included valuable information about risk assessment and management.

We could also see regular recording of one-to-one meetings with people and various members of the multidisciplinary team including nursing, medical, occupational therapy and psychology staff.

We reviewed physical health care plans during our visit, given the recommendation made about this on our previous visit. We saw detailed and comprehensive physical health assessments of people in the service, including monitoring of physical health in relation to specific medical treatments and inclusion in health screening processes that would normally be undertaken by primary care.

Multidisciplinary team (MDT)

The multidisciplinary team comprised of nurses, psychology, occupational therapy, dietician and physiotherapy. We were told that the service does not have significant issues with staffing and only occasionally required to use bank staff.

There is a resident doctor, a staff grade doctor and a consultant psychiatrist. There is a specialist pharmacist who attends the ward meetings. The pharmacist maintained a care plan for each person and provided support to the resident doctors when they were on placement in the rehabilitation ward as to each person's health needs in relation to their specific medical treatment.

There was a weekly multidisciplinary (MDT) meeting in the ward attended by all the multidisciplinary team. The ward was split in to two 'teams' who took turns at the ward meeting. This meant that each person's care and treatment was reviewed at the ward meeting on a fortnightly basis.

The electronic care records included a summary of the MDT meeting, including who was in attendance, the views of people and families and the main discussion and action points.

It was expected that everyone would attend the ward meeting to participate in their care planning. Some of the people we met with told us that it can be "daunting" to attend this meeting due to the number of professionals who were present. One person told us that they understood why so many people were in the meetings, another said that they would like to meet with their doctor alone. We could see that people were able to meet with their doctor and other professionals on a one-to-one basis out with the ward meetings and people told us that they found this helpful.

We were told by the team that there are good links with local social work teams and that the social workers for people with complex discharge care plans were actively involved.

The discharge and resettlement team (DART) would also attend ward meetings as appropriate to each individual's stage of recovery and in their progress towards discharge.

We heard that advocacy services were also regularly involved and saw evidence of their work with individuals.

Senior staff told us that when individuals are working with community support teams, as part of their discharge process, these teams are considered to be part of the wider multidisciplinary team, included in the weekly meetings and involved in developing rehabilitation goals.

We were told by senior staff that there is no community rehabilitation service at this time that can support people at the time of discharge into independent and community living. Occupational therapy will work with individuals at the time of discharge for six weeks, if not longer, and there were links with community organisations, DART and community mental health teams to support individuals at this key time in their rehabilitation. The rehabilitation psychiatrist would also remain involved for a three-month period, at which point the person's care was likely to have been taken over by the community mental health team or other relevant service.

We also heard about the work that happens in the team with regards to specialist training and reflective practice which is supported by psychiatry and psychology staff respectively.

Use of mental health and incapacity legislation

On the day of the visit,10 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We could see information about the mental health act on the ward noticeboards including information about advocacy. The people we spoke to had a good understanding of the legislation they were being treated under, given the length of time that they had been subject to the mental health act, including the availability of advocacy to support them, and their right to appeal.

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment, were reviewed in the electronic care record, were easy to find and up-to-date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. In one case a consent to treatment certificate (T2) did not include all the medication that was prescribed. This issue had already been

identified by the pharmacist and the responsible medical officer was progressing this on the day of our visit.

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 in the person's care record and the involvement of named people in care and treatment was evident from our discussion with people and their care files.

On the day of our visit, there were no people who were subject to other parts of the AWI Act, although where an individual lacked capacity in relation to decisions about their financial affairs, we found that the paperwork relating to management of patient finances was in order. We also saw budgeting and spending care plans in relation to supporting people with their finances.

Rights and restrictions

Whilst the front door to the ward is locked for security purposes, the people in the rehabilitation ward can come and go through an open door at the rear of the ward. This led to a sheltered courtyard, which in turn had open access to the hospital grounds. A sign in/ sign out sheet was in place to record when people were coming and going from the ward.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are subject to detention in hospital. There were no patients on the day of our visit who were subject to these procedures.

At the time of our visit there were no people in the rehabilitation ward who were subject to increased observation practice (also called enhanced or continuous observations).

When we are reviewing individual's 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 saw Advance Statements in the electronic care records of three people that we met with, and one person spoke about working with their advocate to complete an Advance Statement, which detailed their wishes with regards to care and treatment in the future.

Senior staff told us that people can be very unwell when they first come in to the rehabilitation unit and that work on advance statements is more likely to happen when a person is getting ready to move on from the ward.

The Commission has developed *Rights in Mind.*[1] 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

We heard that there were a range of recreational activities available to people in the rehabilitation ward, in addition to some of the therapeutic activities discussed above. The range of activities, along with there always being things to do, was valued by the people in the ward.

During our visit we could see people coming and going from the ward to engage in activities at the on-site Recreational Therapy (RT) department, in addition to spending time in the community and at home. At the time of our previous visit, the RT department had not fully opened post-pandemic; it is now fully operational.

We heard that various members of the multidisciplinary team support the recreational and therapeutic activity programme in the ward. This included occupational therapy, psychology, medical, nursing and RT staff. The activities that were provided by the nursing team in the ward were detailed on a noticeboard in the main ward corridor, including bingo, games and arts and craft. People also had their own activity programme.

One person we met with showed us the artwork they had completed at RT and photographs they had taken and framed during time out with staff. One person told us about the yoga class they had been to that morning in RT. Another person spoke about not wanting to go to RT and other activities they had been able to do instead. They spoke about a volunteer group that they had worked with and a weekly group in which they researched topics online. The person we spoke to was pleased that this had been available and was proud of their achievements in this group. Another person spoke about their involvement in a research project that measured levels of activity in people with psychosis.

We heard that the rehabilitation ward did not have a therapeutic activity nurse, as is available in the other wards in the hospital. Some members of staff told us that they thought that it would be valuable to have a dedicated therapeutic activity nurse. They spoke about times when activities have to be re-arranged when there are not enough nursing staff available and that this can be disruptive and reduce people's opportunities to engage. The people we spoke to did not raise this as an issue and instead spoke very positively about always having things to do. People also spoke about the nursing staff supporting them to go out in to the community to go to appointments, to go shopping and to go to the hairdresser. Nursing staff also told us that they had been able to access therapeutic nurse input from other areas of the

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

hospital for specific individuals in the ward, when this meant that they would be able to offer a specific activity for a person, such as playing guitar.

During our visit we heard about the inpatient community group that happens each month. This provides a forum for the people in the ward to talk about and participate in the planning and delivery of their care and treatment in the ward. We saw a noticeboard in the entrance to the ward which provided a summary of the discussion at the most recent meeting and the action points that had resulted. We could see that the views of all were included in this.

There were a range of group activities in the ward that focused on maintaining a healthy lifestyle, including a focus on a healthy routine, breakfast and lunch groups and access to a therapy kitchen which supported people to self-cater and enhance their cooking skills in the ward. There was also a laundry that people could use and a small kitchen area where people could make hot drinks. The people in the ward took turns to ensure that this area was kept clean as another way to increase domestic skills.

The physical environment

The ward is entered through a door that opens directly in to the ward corridor. The entrance way has a number of noticeboards which provided information about the mental health act, advocacy services, the inpatient community group and activities.

The therapeutic kitchen was next to the entrance and was a big, bright kitchen which was well equipped, with plenty of space for people to use when they were self-catering. People told us that they enjoyed cooking their meals. The kitchen also served as the meeting room on the day of the ward meetings.

The main ward corridor is accessed through double doors from the entrance area.

We viewed all areas of the ward. The main ward corridor leads through the bedroom areas to a small conservatory at the rear. From the conservatory, people could access the small, sheltered courtyard. This was a paved area with plenty of seating leading out on to the hospital grounds. The conservatory opened on to the lounge area that had a large communal television surrounded by armchairs and sofas, in addition to small table and seating areas with books and games on hand.

Adjacent to the lounge area was a dining area which was shared with an adjacent ward. Some people in the rehabilitation ward used the dining area at mealtimes and there was an individualised approach to this. The dining room was large with many tables in front of a small servery. At the time of our visit, only a small number of people in the rehabilitation ward were using the dining room, with the majority using the ward therapy kitchen to prepare their own food.

People could also access a family room, which was available to them when they had visitors, in a corridor which ran alongside the lounge area.

The bedroom facilities comprised of two single sex four-bedded dormitories, each with a shared shower/ toilet facilities and three single bedrooms, two of which have en-suite facilities. The person in the third bedroom has the use of the communal shower and toilet facilities in the ward corridor.

We heard from nursing staff, and saw during our visit, that the floors in the shower rooms had not been updated when flooring had been replaced throughout the ward. We could see that water was not draining from the shower areas and heard that the showers regularly block.

The main ward areas were bright and spacious. The lounge space was homely and had been decorated for Christmas. The dormitory spaces, however, were dark and unwelcoming and we could see that the furniture was outdated and that several of the cupboards that people kept their clothes in were damaged with broken or missing drawers.

People did not raise concerns about the physical environment when we spoke to them. When we asked about the shared dormitory space some people told us that it was better than they had expected and that it did not cause them any problems. We heard that people were respectful of others, that the dormitories were quiet, and that people were often out at activities. One person said that they liked being in the dormitory because “you get to speak to other people”. Another person said that they did not like the dormitory and that the noise from other people disturbed their sleep. We heard about the support that they had had from the nursing team to resolve this issue.

We heard from senior staff that there remained concerns about the ward environment with regards to potential ligature risks and we could see that there were ligature points in the fixtures and fittings in the ward. A risk assessment was recently completed in the ward with regards to environmental risks including ligature risks.

We also heard that people in the ward are not able to keep their charging cables because of service wide requirements. These were stored in a locked room and people had to ask nursing staff to charge their devices for them. Staff were concerned that this did not allow them to take an individualised approach to risk management for the people in the ward, particularly when many of the people were spending a lot of time out of the ward as part of their rehabilitation.

We heard from senior staff and the service manager that the rehabilitation review that was discussed at our previous visit, in connection with the need to upgrade the ward and provide single en-suite bedrooms, had now become incorporated in to a service wide review of inpatient and community provision. We look forward to hearing about this in due course.

Recommendation 1:
Managers should ensure that broken furniture and shower facilities (floors that are not draining and drains that block) are fixed as a priority.

Summary of recommendations

Recommendation 1:
Managers should ensure that broken furniture and shower facilities (floors that are not draining and drains that block) are fixed as a priority.

Good practice

We were told that the rehabilitation service has Royal College of Psychiatrists AIMS accreditation and that they recently completed their third accreditation review.

We heard about an audit that had recently been completed by a resident doctor about the physical health care needs of people in ward and we saw the detailed and comprehensive physical health care plans that resulted from this.

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 Scotland.

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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