To:	**Renfrewshire Integration Joint Board Audit, Risk and Scrutiny Committee**
On:	**15 March 2024**
Report by:	**Head of Mental Health, Learning Disability and Alcohol & Drug Recovery Services**
Subject:	**Mental Welfare Commission for Scotland: Inspection Reports for South Ward, Dykebar Hospital and Ward 3B, Leverndale Hospital**

1. Summary

1.1 The Mental Welfare Commission for Scotland (MWC) is an independent organisation that is accountable to the Scottish Government for its statutory duties. They are responsible for safeguarding the rights and welfare of people in Scotland with a mental illness, learning disability or other mental disorder. They carry out their statutory duties by focussing on five main areas of work: visiting people/services, monitoring the Acts; investigations; information, and advice; and influencing and challenging.

1.2 MWC visits to adult mental health wards are facilitated in two ways. Planned visits are communicated directly to the ward, and Operational Managers 6 weeks in advance of a visit. Posters and letters are provided by the MWC to inform service users and carers of the visit to give them the opportunity to provide feedback to the MWC on family/carer involvement and patient care within the ward. The MWC review patient records and legal documentation to ensure that statutory duties are being met and that the quality of care provided meets expected standards.

1.3 Unannounced visits involve the MWC visiting a ward without prior communication. These visits concentrate on legal documentation, quality of care and progress on the recommendations from previous visits.

1.4 Following both types of visits, the MWC provide a written report on their findings and recommendations on improvements. An action plan, based on the recommendations, must be completed, and returned to the MWC within three months of receipt of the report.

1.5 Renfrewshire HSCP ensures action plans are progressed and monitored through Mental Health and HSCP-wide Clinical and Care Governance structures.

1.6 All NHSGGC-wide MWC reports, and action plans are collated and circulated on a quarterly basis, with progress and monitoring of action plans managed by NHSGGC Board-wide MH Clinical and Care Governance and Programme Board structures.

1.7 This report summarises the announced visit to Ward 3B Levendale Hospital on 28 November 2023 and the unannounced visit to South Ward, Dykebar Hospital

on 14th December 2023. Both reports are appended respectively in Appendixes 1 and 2 to this report.

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2. Recommendations

It is recommended that the IJB Audit, Risk and Scrutiny Committee:

- Note the content of this report.

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3. Background and Context

3.1 The MWC arranged an announced visit to Ward 3B, Leverndale Hospital, for 28th November 2023. The MWC combined the visits of Ward 3B and Ward 3A, Leverndale Hospital, in a single report. Ward 3A is managed by Glasgow City HSCP. However, the findings and recommendations were individualised for both wards. Following the visit, the MWC made two recommendations for Ward 3B.

3.2 The MWC met with and reviewed the care of twelve individual patients. They also met with two carers, who had made appointments with them. Feedback provided by patients was positive, with staff described as 'brilliant', 'always willing to help' and 'they are so lovely'. Patients also reported that they enjoyed a range of recreational therapies such as on-site gym sessions, creative writing, art therapy, relaxation, gardening, and walking groups.

Summary of Recommendations

1. **Managers responsible for Ward 3B should ensure that risk assessment documentation is reviewed regularly and updated accordingly.**

The risk assessments reviewed on Ward 3B showed that review and updates were taking place, but this was not consistent. It was noted by the MWC that the completion of the risk assessments was compliant with the NHS GGC Risk Assessment Policy but they advised that clear recordings of risk assessment discussions in the MDT meeting, even when there is no change, would benefit from noting that a review had taken place.

2. **When someone is made a specified person, Psychiatrists and Managers on Ward 3B should ensure, where appropriate, they are provided with the required written notification about the restrictions applied, timescales involved and right of appeal.**

Sections 281 to 286 of the Mental Health Act relate to specified person restrictions, which are the appropriate legal safeguard when placing restrictions on an individual who is detained in hospital. The MWC have said that patients subject to such measures should receive notification in writing about restrictions applied, timescales involved and their right of appeal, unless doing so would be detrimental to their mental health.

The patient within Ward 3B that had been designated as a Specified Person had received verbal notification of the restrictions; however, they did not receive this in writing.

Positive findings and Good Practice:

- Feedback provided by patients and carers was positive. Staff had a good understanding of individual needs and showed a commitment to supporting those they cared for.
- The ward displayed information to support carers, including access to local support groups.
- The ward is involved in patient conversations (A patient and carer feedback process facilitated by the Mental Health Network).
- Care plans were accessible with person centred goals that were regularly reviewed. Individuals had a detailed understanding of the goals on their care plans, reporting regular one-to-one time with nursing staff, and had signed copies of their care plans.
- Trauma informed approaches training is being rolled out to staff.
- The ward has a full-time community mental health social worker, which has helped to progress assessments for individuals.
- All T2 and T3 forms were correct and in place.
- Patients were aware of and had access to advocacy services.
  Patients felt that contact with their family was supported and were happy with their relatives' involvement in their care.
- Individuals enjoyed a range of activities on both wards, and at the onsite recreational therapy centre.

Other findings and comments

- Several patients and staff advised that the ward is tired looking and required upgrading.

- The environment remains an ongoing challenge for staff to prioritise space based on individual need and risk assessment. The MWC stated that these issues can only be changed by reconstruction and redesign of the environment.

- Improvements have been made to the decoration and furniture of the ward, over the last year. However, the layout of the ward is dated and not ideal for an Adult Mental Health Admission Ward. Poor natural light, large sitting rooms that have corridors running through them, a lack of interview rooms and dining & garden space shared between two wards can have an impact on the general feel of the ward and to patients' recovery.

- These issues related to the fabric and design of the ward/s are highlighted as part of the GGC-wide Mental Health Strategy and programme of work related to in patient and wider community mental health transformation.

3.3 The MWC published their report for Ward 3B on 8 January 2024 and the deadline for the return of the action plan is 8 April 2024

3.4 The MWC carried out an unannounced visit to South Ward, Dykebar Hospital on 14 December 2023. Following the visit, the MWC made four recommendations.

Summary of Recommendations

1. **Managers should audit care plans to ensure they are person centred and consistently record all needs relating to patient care.**

   Although most care plans were person-centred and comprehensive, a care plan for a patient with an eating disorder had not been fully developed to support specific interventions during Naso-Gastric feeding and in relation to self-harm.

2. **Managers should ensure the review and audit of medication records for individuals requiring T2 and T3 certificates to authorise their treatment under the Mental Health Act is carried out and findings acted upon timeously.**

   Part 16 of the Mental Health Act sets out conditions under which treatment may be given to individuals subject to compulsory measures, who are either capable or incapable of consenting to specific treatments, including medications. To authorise treatment, T2 certificates should be used for individuals who can consent, and for those who cannot consent, T3 certificates should be used.

   The MWC reviewed all T2 and T3 certificates and found discrepancies with two T2 forms; one was missing prescribed medication, and another noted intramuscular medication to be given only as required when the patient was refusing and/or unable to consent, therefore the T2 was not appropriate. Additionally, the MWC noted that an as required medication had not been administered in the last year, and required review.

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

   The MWC noted that one patient's Specified Person documentation only had a reasoned opinion for restricting telephone use, despite safety and security restrictions also being applied.

4. **Managers should update the commission on the progress of reviewing the safety and privacy issues raised in relation to the use of magnetic en-suite doors.**

   Saloon-style, magnetic en-suite toilet doors in bedrooms are being introduced, in all NHS GGC mental health wards, as a ligature reduction measure. The MWC have stated in a number of reports for different wards across NHS GGC that the doors fell off easily and that they considered this to be a safety issue. The MWC also said that several patients they met with commented that they did not feel the doors afforded appropriate privacy.

   The NHS GGC Suicide Risk & Design Group introduced reduced ligature doors following the suicide of two patients using ligatures tied to the original doors. Several reports have also highlighted en-suite bathroom doors in mental health wards as being one of the highest risks for patient suicide attempts in mental health hospitals, when using a ligature. The group are aware of the issue with the magnets on some doors and have a plan to replace these with stronger magnets.

Positive findings and good practice

- Consistent records of care plans with reviews and progress notes clearly documented. Care plans related to risk assessments as well as being regularly discussed at weekly multidisciplinary team (MDT) meetings.
- Patients felt involved in their care planning and reported regular one-to-one time with nursing staff and psychiatrists. Individual participation was evident in the recording of views in the care plans, the MDT meetings and nursing notes.
- Staff had a good understanding of individual need, including working with those who experienced an eating disorder and physical health conditions.
- Patients felt involved in MDT meetings, with their views being consistently recorded. Family members were regularly invited, with their views documented in the record of the meeting.
- The legal status of individuals subject to the Mental Health Act was clear and accessible on the electronic recording system.
- Those patients subject to detention under the Mental Health Act had been advised of their rights verbally and in writing; those who were subject to detention were either accessing, or knew how to access, advocacy services.
- Patients informed the MWC that they enjoyed a range of activities on the ward. Activities were supported by the occupational therapy and physiotherapy teams and were offered on a group, or one-to-one basis.
- Several individuals stated that nursing staff arranged ward-based activities during the weekend, such as organising walks.
- South Ward was spacious, bright, and welcoming with patient's artwork displayed throughout the ward. There are accessible bedrooms for assisted individuals, with quieter spaces to accommodate varying needs.
- The garden facilities were tidy and clean and could be enjoyed by individuals and visitors throughout the year, weather permitting.

Other findings and comments

- Patients progressing in their discharge felt supported by occupational therapy, physiotherapy, and the discharge coordination team.
- There was evidence of community service involvement in discharge planning, including social work, community mental health teams and housing services, to support the recovery of individuals upon discharge.

3.5 The MWC published their report for South Ward on 21 February 2024 and the deadline for the return of the action plan is 8 May 2024.

4. Next Steps

4.1 Action plan recommendations will be progressed, and progress monitored through relevant HSCP and Boardwide governance structures.

Implications of the Report

1. **Financial** – None
2. **HR & Organisational Development** – None
3. **Community Planning –** None
4. **Legal** – None

5. **Property/Assets** – None
6. **Information Technology** – None
7. **Equality & Human Rights** - None
8. **Health & Safety** - None
9. **Procurement** – None
10. **Risk** - Failure by services to meet and exceed the MWC Standards could lead to poor inspection results, as well as negative outcomes for service users and carers.
11. **Privacy Impact** - None

List of Background Papers – None

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mental welfare commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to:

Leverndale Hospital, Ward 3A and Ward 3B, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 28 November 2023

Where we visited

Ward 3A is an adult acute mental health admission ward that covers the geographical area of South Glasgow including Barrhead, Pollock and Crookston. The ward has 24 beds and is divided into two inpatient areas that have single and dormitory bedrooms.

Ward 3B is also an adult acute mental health admission ward and is managed offsite by Dykebar Hospital, and covers the Renfrewshire area. The ward has 24 beds and is divided into two inpatient areas that have single rooms and dormitory bedrooms. Ward 3B has responsibility for ESTEEM, a mental health service for individuals aged between 16 and 35 years old, who are experiencing a first episode of psychosis.

At our last visit to Ward 3A was in May 2022, and we made three recommendations, and when we previously visited Ward 3B in November 2022, we made two recommendations. Recommendations included care plan auditing, supporting visiting arrangements and activity provision.

On the day of our visit, we wanted to follow up on recommendations and any progress made. We also wanted to speak with individuals and staff, and listen to their views on care, treatment, and the environment.

Who we met with

We met with and reviewed the care of 18 individuals, and we reviewed the care notes of one further individual. We also spoke with two relatives on the day of our visit.

We met with allied health professionals, senior charge nurses (SCN), charge nurses (CN) and staff nurses.

Commission visitors

Gemma Maguire, social work officer

Kathleen Taylor, engagement and participation officer

Mary Hattie, nursing officer

Douglas Seath, nursing officer

What people told us and what we found

Feedback provided by individuals from both wards was positive, with staff described as 'brilliant', 'always willing to help' and 'they are so lovely'. Staff we spoke with had a good understanding of individual needs and showed a commitment to supporting those they cared for.

Individuals from both wards reported to us that they enjoyed a range of recreational therapies such as on-site gym sessions, creative writing, art therapy, relaxation, gardening, and walking groups.

Care, treatment, support and participation

Relatives we spoke with on the day of the visit reported that staff listened to their views, and that they felt included in decision-making regarding their loved ones. We were pleased to see that both wards displayed information to support carers, including access to local support groups.

The Commission have published a good practice guide on carers and confidentiality. The guide is to help carers and families understand consent, confidentiality, and sharing of information. It will also guide health and social care practitioners and can be found at:

2018_update_carers___confidentiality_final_draft_16_oct_2018.pdf (mwcscot.org.uk)

Both wards are involved with 'patient conversations' which is delivered by individuals with lived experience, promoting values of empowerment and recovery. We were pleased to learn that Ward 3A have recently started community meetings to encourage participation. Across both wards, individuals we spoke with felt they could express views and that they were involved in their care.

Care Planning

On our last visit to each ward, we made recommendations relating to care plan auditing, reviews and ensuring person-centred approaches were consistently carried out. We were pleased to find that care plans were accessible with person-centred goals that were regularly reviewed. Several individuals we spoke with had a detailed understanding of the goals on their care plans, reporting regular one-to-one time with nursing staff, and had signed copies of their care plans.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/node/1203

Care and Treatment experienced by individuals.

We were advised individuals may be admitted to Ward 3A for care and treatment in relation to eating disorder. We heard staff described as 'lovely' however, there was a sense that there was a lack of understanding regarding the needs of eating disordered individuals; an example of this that we heard about was when individuals are questioned around already agreed diet

plans. We discussed these issues on the day of the visit and were advised the ward has access to the in-reach specialist eating disorder services, as well dietician and psychology input. Recent staffing changes were discussed, and we were advised that previously trained staff, with experience of supporting individuals with eating disorder, had left the service. We were informed that training in relation to eating disorders is available and will be progressed with the current staff group. We look forward to seeing progress in this area at future visits.

The Commission has published a themed visit report looking at eating disorder services across Scotland. People who provide care, treatment, and support for people with eating disorders can read this report and reflect on their current practices. The report can be found at EatingDisorders_ThemedVisitReport_03Sept2020_0.pdf (mwcscot.org.uk)

Individuals we spoke with on Ward 3B reported that whilst most staff are 'excellent', some reported 'staff are changing all the time'. We were advised by one individual that their named nurse was 'brilliant', however some staff 'change the rules' and "I have to keep telling them about my care plan". All individuals we spoke with felt able to raise concerns with named nurses and/or the CN in the ward. We discussed the issues raised regarding perceived staff behaviours with Ward 3B managers on the day of our visit. We were advised that several experienced staff have moved on, however recruitment work undertaken by the service has helped to fill all vacancies on Ward 3B.

We were also informed that agency staff are no longer used by the service. Instead, bank staff are used which provides more consistency when supporting patient safety during increased use of observations. We were told that training will be rolled out with nurses, bank staff, and health care assistants, to ensure trauma-informed approaches are understood by all staff. We look forward to hearing progress on future visits.

Issues raised by individuals regarding perceived staff behaviours are being followed up separately.

Multidisciplinary team (MDT)

MDT meetings continue to be held weekly in Ward 3A and Ward 3B, with consultants visiting the wards and meeting individuals throughout the week. We were pleased to hear individuals felt involved in meetings, with views consistently recorded. Ward 3A has six inpatient consultants who also cover outpatient services at Florence Street and Rossdale mental health resource centres. Ward 3B has three inpatient consultants, one of whom is responsible for ESTEEM, a mental health service for people aged 16-35 years old, who experience a first episode of psychosis and require in-patient care. At the time of our visit four individuals were admitted under this service.

Ward 3A and Ward 3B MDT meetings also included pharmacy, dietician, and occupational therapy. We were pleased to hear that family members were regularly invited, with their views recorded in meetings. We were also advised that both wards have access to psychology services.

Hospital discharge

On the day of our visit no one was reported to be delayed in their discharge from hospital. We spoke with one individual who expressed concern regarding a lack of progress in their discharge after being admitted to Ward 3B for three years. The individual had raised their concerns with their MDT, as well as exercising right of appeal under the Mental Health Act. We reviewed the individual's notes and found clear MDT discussion involving social work, demonstrating various attempts to source appropriate care and support to meet the individual's complex needs. Issues raised by individuals in relation to their discharge is also being followed up separately.

In discussion with the CN, we were advised that Ward 3B have a full-time community mental health social worker attached to the ward, which has helped to progress assessments for individuals. On Ward 3A we were pleased to learn that the role of the integrated discharge coordinator liaises with HSCP's, which has in turn provided earlier access to social work assessment and services for many individuals.

Managers of both services advised us that where an individual is delayed in their discharge from hospital, there are escalation processes in place, with regular auditing and scrutiny involving senior managers across the HSCP's. For those we spoke with and/or reviewed, there was evidence that the current level of care and treatment was required, and discharge planning was progressing where appropriate.

Risk Assessment

During our visit we noted that individuals on Ward 3A had risk assessments consistently reviewed and updated, which we considered to be a best practice approach. The risk assessments we reviewed on Ward 3B showed that review and updates were taking place, but this was not consistent. We were advised, in line with service policy, that risk assessment documents are only updated when there is a change. We advised Ward 3B managers that clear recording of risk assessment discussions that take place in the MDT meeting, even where there is no change, would be benefit from noting that a review had taken place.

Recommendation 1:

Managers responsible for Ward 3B should ensure that risk assessment documentation is reviewed regularly and updated accordingly.

Use of Mental Health and Incapacity legislation

On the day we visited 14 individuals on Ward 3A, and 18 individuals on Ward 3B, were subject to The Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The legal status of individuals subject to the Mental Health Act was clear and accessible on electronic recording systems across Ward 3A and Ward 3B.

Part 16 of the Mental Health Act sets out conditions under which treatment may be given to individuals subject to compulsory measures, who are either capable or incapable of consenting to specific treatments, including medications. To authorise treatment, T2 certificates should be used for individuals who can consent, and for those who cannot

consent, T3 certificates should be used. We reviewed all T2 and T3 certificates and found these were correct and in place.

On the day we visited, one individual reviewed in Ward 3A was subject to a welfare guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) . There was no information about the guardianship or copies of the powers in the file, and staff were unaware the order was in place. Under the AWI Act, a section 47 certificate and treatment plan should be completed by a doctor where an adult is assessed to lack capacity regarding medical decisions. The individual subject to guardianship in Ward 3A had been assessed to lack capacity relating to medical decisions, however no s47 certificate had been issued to authorise medical treatment.

Issues in respect of the AWI Act were discussed with staff and managers for Ward 3A on the day of our visit. We were advised copies of the guardianship powers and requirement for s47 certificate would be followed up.

Recommendation 2:
Managers responsible for Ward 3A should ensure copies of welfare guardianship powers are available for relevant staff and these powers are clearly documented in notes.

Recommendation 3:
Managers responsible for Ward 3A should ensure adults assessed as lacking capacity regarding medical decisions have section 47 certificates and treatment plans in place to authorise medical treatment.

The Commission is working in partnership with NHS Education for Scotland to develop learning resources for the workforce to support and promote people's rights in the application of AWIA. Learning resources can be accessed here:

Adults with Incapacity Act | Mental Welfare Commission for Scotland (mwcscot.org.uk).

Rights and restrictions

We were pleased to note that individuals subject to detention under the Mental Health Act had been advised of their rights verbally and in writing, and they informed us that they understood the specifics of their detention under the Act; we also heard that they were either accessing, or knew how to access advocacy services.

During our last visit to Ward 3A, Covid-19 visiting restrictions were in operation, and we recommended that visiting procedures should be updated in line with Scottish Government guidelines. We were pleased to find that visiting was now only restricted to protect mealtimes. Those that we met with felt contact with their family was supported and were happy with their relatives involvement in their care.

Sections 281 to 286 of the Mental Health Act relate to specified person restrictions, which are the appropriate legal safeguard when placing restrictions on an individual who is detained in hospital. Making someone a specified person should be the least restrictive option and where not doing so would place them, or others, at significant risk of harm. The individual subject to

such measures should receive notification in writing about restrictions applied, timescales involved and their right of appeal, unless doing so would be detrimental to their mental health.

During our visit, two individuals on Ward 3A, and one individual on Ward 3B, were found to be specified. For the individuals on Ward 3A, documentation relating to this, including reasoned opinion, was appropriately in place. The individual on Ward 3B informed us that they had received verbal notification of the restrictions; however nothing was provided to them in writing. Upon review of documentation, whilst there was a reasoned opinion available, there was no record of written notification being provided to the individual. We discussed this issue with staff on the day of the visit and were advised this would be follow up.

Recommendation 4:
When someone is made a specified person, psychiatrists, and managers on Ward 3B should ensure, where appropriate, they are provided with the required written notification about the restrictions applied, timescales involved and right of appeal.

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 (mwcscot.org.uk)

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and Occupation

Individuals told us they enjoyed a range of activities on both wards, and at the onsite recreational therapy (RT) centre. Information on each ward's activities was on display with a range to choose from.

The RT centre offers music and art groups, creative writing, gardening, football, and walking groups Monday to Friday. Following our last visit, we recommended that individuals on Ward 3B were given equitable access to the RT centre. We were pleased to find that this has been addressed and individuals from Ward 3B can access the RT centre in line with other Leverndale Hospital wards.

Individuals on Ward 3B benefit from ward-based activities, supported by the occupational therapy team. There is access to a therapy room for relaxation, art and music activities as well as use of gym equipment. Ward 3B also has access to a therapy kitchen which supports the development of cooking skills and functional assessments in preparation for discharge.

Ward 3A activities are supported by the Therapeutic Activity Nurse (TAN), who provides one-to-one discussions, bingo, karaoke, and walks. Several individuals that we spoke with told us how much they enjoyed this service. The TAN provides a service five days out of seven, ensuring some weekend activities are available to individuals. This is beneficial given availability of activities is reduced at weekends when the RT centre is closed.

The physical environment

Several individuals and staff that we spoke with during the visit advised us that the general physical environment on both wards is 'tired looking' and 'could be doing with an upgrade'. Staff and individuals have made attempts to visually improve the environments, by displaying artwork and posters throughout the wards.

Whilst both wards each have access to two single bedrooms, the majority of individuals are accommodated in shared dormitories. We heard from some individuals that they enjoy the company that a dormitory room offers them, whilst others told us they would prefer the privacy of having their own bedroom. One individual told us they were physically assaulted by another patient in the dormitory and whilst they praised staff for their support in relation to this, they were of the view that this happened because of the shared dormitory environment. The incident was responded to appropriately, and dealt with in line with local procedures, including incident review and updated risk assessments.

The environment remains an ongoing challenge for staff to prioritise space based on individual need and risk assessment. As discussed in our previous visits, issues can only be changed by reconstruction and redesign of the environment.

Summary of recommendations

Recommendation 1:
Managers responsible for Ward 3B should ensure that risk assessment documentation is reviewed regularly and updated accordingly.

Recommendation 2:
Managers responsible for Ward 3A should ensure copies of welfare guardianship powers are available for relevant staff and these powers are clearly documented in notes.

Recommendation 3:
Managers responsible for Ward 3A should ensure adults assessed as lacking capacity regarding medical decisions have section 47 certificates and treatment plans in place to authorise medical treatment.

Recommendation 4:
When someone is made a specified person, psychiatrists, and managers on Ward 3B should ensure, where appropriate, they are provided with the required written notification about the restrictions applied, timescales involved and right of appeal.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report.

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 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.

Contact details

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Mental Welfare Commission 2022

mental welfare commission for scotland

Mental Welfare Commission for Scotland

Report on unannounced visit to:

South Ward, Dykebar Hospital, Grahamston Road, Paisley, Renfrewshire, PA2 7DE

Date of visit: 14 December 2023

Where we visited

South Ward is an adult acute mental health admission ward and covers the geographical area of Paisley and Renfrewshire. The ward has 15 single rooms with en-suite facilities. There were no empty beds on the day we visited.

On our last visit in November 2022, we made two recommendations regarding care plan auditing and authorisation for medication. On the day of this visit, we wanted to follow up on the recommendations and any progress made. We also wanted to speak with individuals and staff, and listen to their views on the care, treatment, and environment.

Who we met with

We met with and reviewed the care of four patients, and we reviewed the care notes of a further three individuals.

We met with allied health professionals, the charge nurses (CNs), staff nurses and nursing assistants.

Commission visitors

Gemma Maguire, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Feedback provided by those that we spoke with was positive and we heard how individuals felt 'listened' to by staff. Staff we spoke with had a good knowledge of those they cared for and we observed warm and caring interactions in a calm environment throughout the day.

We heard about how people enjoyed a range of recreational and occupational therapies, such as art, creative writing, gardening, and walking groups.

Care, treatment, support and participation

Care Planning

At our last visit, we made a recommendation in relation to care plan audits, to ensure recording of individual progress was reviewed. During this visit we observed consistent records of care plans with reviews and progress notes clearly documented. We found care plans to be accessible in paper files, relating to risk assessment as well as being regularly discussed at weekly multidisciplinary team (MDT) meetings.

Those individuals we spoke with felt involved in their care planning and reported regular one-to-one time with nursing staff and psychiatrists. Individual participation was evident in the recording of views in the care plans, the MDT meetings and nursing notes.

Staff we met with provided us with a good understanding of individual need, including working with those who experienced an eating disorder and physical health conditions. Staff told us about the needs of an individual with epilepsy, however on reviewing care plans there were no specific details on how the condition was being managed. We heard how the practical and

emotional support provided by staff during nutrition by nasogastric (NG) feeding could significantly ease distress. Staff knowledge of eating disorders, when supporting incidents of self-harm, was also beneficial in providing an alternative view to their MDT colleagues. On reviewing notes, we found that care plans for those with an eating disorder had not been developed to support specific interventions during NG feeding and in relation to self-harm. Having a structured plan around all assessed needs would ensure a consistency of approach and enhance the individual's care experience. We brought these issues to the attention of the CN and managers on the day of our visit and were advised that care plans would be updated to reflect the specific interventions. We look forward to seeing progress on our next visit.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:

Managers should audit care plans to ensure they are person-centred and consistently record all needs relating to patient care.

Multidisciplinary team (MDT)
MDT meetings continue to be held weekly on South Ward, with consultants visiting the ward and meeting patients throughout the week. The MDT consists of two consultant psychiatrists, junior doctors, nurses, pharmacy, psychology, discharge coordinator, physiotherapy, and occupational therapy. We were pleased to hear individuals felt involved in meetings, with their views being consistently recorded. Family members were regularly invited, with their views documented in the record of the meeting.

Some individuals we met with were progressing in their discharge from South Ward and told us they felt supported by occupational therapy, physiotherapy, and the discharge coordinator team. We heard how community services are involved in discharge planning, including social work, community mental health teams and housing services to support the recovery of individuals upon discharge.

Use of mental health and incapacity and adult protection legislation

On the day of our visit, there were eight individuals in South Ward who were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The legal status of individuals subject to the Mental Health Act was clear and accessible on the electronic recording system.

Part 16 of the Mental Health Act sets out conditions under which treatment may be given to individuals subject to compulsory measures, who are either capable or incapable of consenting to specific treatments, including medications. To authorise treatment, T2 certificates should be used for individuals who can consent, and for those who cannot consent, T3 certificates should be used. We reviewed all T2 and T3 certificates and found discrepancies with two T2 forms; one was missing prescribed medication, and another noted

intramuscular medication to be given only as required when the patient was refusing and/or unable to consent, therefore the T2 was not appropriate. Additionally, we noted that an as required medication had not been administered in the last year, and required review. These issues were discussed with the CN on the day of our visit who agreed to follow this up with the psychiatrists.

Recommendation 2:

Managers should ensure the review and audit of medication records for individuals requiring T2 and T3 certificates to authorise their treatment under the Mental Health Act is carried out and findings acted upon timeously.

The Adult Support and Protection (Scotland) Act 2007 (the ASP Act), provides a legislative framework when working with vulnerable adults at risk of harm. Two case records that we reviewed had appropriate documentation and recording in relation to the ASP Act, including referrals made by the service.

Under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act), a section 47 certificate should be completed by a doctor where an adult is assessed to lack capacity regarding medical decisions. Where individuals had been assessed regarding this, we found the relevant section 47 certificate.

Rights and restrictions

We were pleased to note that those subject to detention under the Mental Health Act had been advised of their rights verbally and in writing; those who were subject to detention were either accessing, or knew how to access, advocacy services.

Sections 281 to 286 of the Mental Health Act relate to specified persons, a legal safeguard required when placing restrictions on an individual who is detained in hospital. Making someone a specified person should be the least restrictive option and where not doing so would place them, or others, at significant risk of harm. During our visit, one individual was found to be specified. We noted that the documentation only had a reasoned opinion for restricting telephone use, despite safety and security restrictions also being applied. This was discussed with the charge nurse on the day of our visit who agreed to notify the psychiatrist for follow up.

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 (mwcscot.org.uk)

Recommendation 3:

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

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

in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

Those that we spoke with on South Ward told us that they enjoyed a range of activities on the ward. Activities were supported by the occupational therapy and physiotherapy teams and were offered on a group, or one-to-one basis. We heard from several individuals that nursing staff arranged ward-based activities during the weekend, such as organising walks.

South Ward also has access to an occupational therapy kitchen which supports the development of cooking skills and functional assessments in preparation for discharge.

The physical environment

South Ward was spacious, bright, and welcoming with patient's artwork displayed throughout the ward. There are accessible bedrooms for assisted individuals, with quieter spaces to accommodate varying needs.

The garden facilities were tidy and clean and could be enjoyed by individuals and visitors throughout the year, weather permitting.

We observed magnetic, partial en-suite toilet doors in bedrooms which we noted fell off easily and we consider this to be a safety issue. Some individuals we met with commented that they did not feel the doors afforded appropriate privacy. In discussion with managers, we were advised the doors, along with other ward furniture, are being reviewed as part of service-wide risk assessment and management. We look forward to seeing progress on our next visit.

Recommendation 4:

Managers should update the commission on the progress of reviewing the safety and privacy issues raised in relation to use of magnetic en-suite doors.

Any other comments

Some staff we met with reported that until recently staffing and ward capacity felt 'unmanageable'. We were advised South Ward historically received all acute mental health inpatient admissions for the Renfrewshire area. We also heard of pressures on senior charge nurse (SCN) and CN posts caused by long term staff absences, staff leaving posts, and others being moved to provide cover elsewhere.

We were pleased to hear that managers have taken steps to ease pressures on the service; Ward 3B in Leverndale Hospital now receives inpatient admissions alongside South Ward and staff retention and recruitment are a key service priority. On the day we visited, there were no SCN or CN vacancies and one CN had been temporarily moved to provide cover in another ward. We heard from several staff and patients that the ward felt less 'chaotic' with staff being more consistently available.

Summary of recommendations

Recommendation 1:

Managers should audit care plans to ensure they are person centred and consistently record all needs relating to patient care.

Recommendation 2:

Managers should ensure the review and audit of medication records for individuals requiring T2 and T3 certificates to authorise their treatment under the Mental Health Act is carried out and findings acted upon timeously.

Recommendation 3:

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

Recommendation 4:

Managers should update the commission on the progress of reviewing the safety and privacy issues raised in relation to the use of magnetic en-suite doors.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report.

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 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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Mental Welfare Commission 2022