Mental Welfare Commission for Scotland

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

Date of visit: 3 November 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits, however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out face-to-face.

Banff Ward is a 20-bedded mixed-sex assessment ward for older people with a functional mental illness, the ward has six single en-suite bedrooms and a number of dormitories. We last visited this service on 28 August 2018 and made recommendations in relation to care planning, recording of activities, and meal provision.

On the day of this visit we wanted to follow up on the previous recommendations and also look at communication with relatives, and activity provision. This is because the pandemic has impacted significantly on relative's ability to visit and keep in contact with patients, and with the provision of activities within wards, with voluntary provision being suspended and restrictions on group working and staff movement.

Who we met with

We met with and/or reviewed the care and treatment of nine patients and spoke with five relatives.

We spoke with the service manager, and the acting senior charge nurse (SCN).

Commission visitors

Mary Hattie, Nursing Officer

Mary Leroy, Nursing Officer

What people told us and what we found

All of the relatives we spoke with were very positive about the care provided in the ward. We were told that medical and nursing staff keep them informed and involved in decisions about care, and that staff go "above and beyond" in ensuring their loved ones needs are met and provided us with some examples of this.

Care, treatment, support and participation

The ward has input from five consultant psychiatrists who cover the catchment area. There is regular input from occupational therapy (OT), psychology, physiotherapy and pharmacy. Input from other professionals including dietetics and speech and language therapy is arranged on a referral basis. Multidisciplinary Team (MDT meetings are held weekly for each consultant. Attendance at MDT meetings has recommenced in person with the exception of social work and community psychiatric nurses, who join the meeting virtually. We are told this virtual attendance has facilitated a greater level of engagement from the community staff.

The MDT reviews were clearly documented, including a list of those present at the meeting, an update on the patients' current situation, detail of the discussion, decisions made, and a clear action plan.

From discussions with relatives and from the chronological notes, we found that communication with relatives is good. We also heard from some of the patients that we spoke with that staff discussed their care with them and they were aware of what was in their care plans. However this patient participation is not being recorded in the care plan itself.

In the files we reviewed we found that care plan goals were person-centred. There was evidence of meaningful, detailed regular evaluations of care, however the interventions within the care plan outlined a framework, but did not contain any detail of the actions required for the individual patient and this was not updated to incorporate the information gathered and outcome of the care reviews. As a result care plans were static documents, missing important information gathered since admission and did not reflect patients current care needs and interventions.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Recommendation 1:

Managers should audit care plans on a regular basis to ensure the interventions are person centred, care plans are updated following evaluations to reflect any changes in the individuals care needs, and legal status and that patient participation is recorded.

Use of mental health and incapacity legislation

Where patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), copies of the detention paperwork were on file. However, in the majority of the files we reviewed we found that where patient's detention status had changed, whilst this was recorded in the chronological notes, the care plan was not updated to reflect this change.

Part 16 (s235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. We found that one patient did not have a T3 in place; however a request for a DMP visit had been submitted. We found two patients had 'as required' medication prescribed which was not included on the T3. We requested that the consultant be contacted to address this.

Where individuals have granted a Power of Attorney (POA) under the Adults with Incapacity (Scotland) 2000 Act ('the AWI Act') it is important that this information is available within patient's file, so that staff are aware of the powers held and proxies are consulted appropriately. We reviewed the files of two patients who had a welfare POA in place; in one file copies of the powers were present, and, from discussion with the proxy and from the notes, the proxy was clearly being consulted appropriately. However there was no note within the care plan or chronological notes that there was a POA in place.

One relative advised they held welfare POA, but that they had never been asked about this and had not been advised to provide a copy of the powers. They told me they were involved in decisions about their loved ones care and had no concerns about how they were consulted. However, again, there was no record of there being a POA in place within the care plan or chronological notes.

Section 47 of the AWI Act authorises medical treatment for people who are unable to give consent. Under S47 a doctor (or another healthcare professional who has undertaken the specific training) examines the person and issues a certificate of incapacity.

We found s47 certificates in place for the patients whose files we reviewed, who lacked capacity to consent, authorising their treatment under the AWI Act. Where there was a proxy decision maker in place we found evidence that they had been consulted about the granting of the certificate and treatment decisions

Recommendation 2:

Managers should put an audit system in place to ensure that all medication prescribed for patients who are subject to compulsion under the Mental Health Act is properly authorised.

Recommendation 3:

Managers should put a system in place to ensure that where there is a proxy decision maker this is recorded and a copy of the powers are held in the patient's file.

Rights and restrictions

The ward has a locked door policy and information on this is provided.

The ward has access to advocacy and a number of the patients whose care we reviewed had used the advocacy service. During the visit we identified two patients who we felt would benefit from Advocacy involvement and we asked that they be referred.

Since the easing of restrictions on visitors to the hospital the ward has recommenced its open visiting policy. We are told that the ward has adequate space to meet the level of visitors they are experiencing and visits no longer need to be booked in advance.

A number of relatives spoke of how difficult they found it when they were unable to visit or take their loved ones out during the restrictions. They also told us they are now being encouraged to take patients out, either to visit their homes or to spend time in the community. In the notes we reviewed we found evidence of patients being supported to go out into the community either with staff or relatives.

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

Activity and occupation

The ward has dedicated OT sessions which allows for the provision of activities such as cookery and craft groups, as well as assessments of patients. The physiotherapist provides a regular tai chi class as well as input to individual patients, and the recreational therapy department also provides input. We were told that a therapeutic activity nurse has just been appointed, who will work across Banff and Balmore wards. This dedicated resource will enable further development of activities within the unit. Due to the pandemic, activities such as therapet visits and music in hospitals were suspended, and these have not yet recommenced.

There is an activity board; however, we heard that the majority of the activity provision is ad hoc and is decided in consultation with the patients at the time. During our visit we saw patients playing dominoes and bingo and enjoying reading newspapers and chatting with staff.

In our previous report we made a recommendation that activity participation should be recorded. We found good recording of activity participation within the chronological notes we reviewed. This included: going to church, listening to music, utilising personal computers, arts and crafts and personal care such as having hair and nails done. This was clearly linked to personal preferences and choice.

Several of the relatives we spoke to mentioned the activities within the ward, saying their loved one was often engaged in a group activity when they visited. The patients we spoke to told us they enjoyed the activities on offer.

The physical environment

The ward is bright and spacious. It benefits from having a pleasant secure garden, accessible off the main sitting area. There is a large conservatory which provides a quieter environment than the main sitting room. There is also an activity room and laundry facilities for individuals who wish to do their own laundry. There is a small pantry on the corridor which houses the sleeping accommodation, which enables staff to provide hot drinks and snacks for patients if they are unable to sleep. Since our last visit the ward has benefited from the provision of a therapeutic kitchen, which enables occupational therapy staff to undertake kitchen assessments and cookery groups on site.

Any other comments

In our previous report we made a recommendation in relation to meal provision. On this visit we looked at the menu choices and discussed these with the SCN who advised that there were no issues with meal provision, choice was reasonable and varied and there were always options for special diets and facilities to provide food outside of meal times should this be required. The patients we spoke to about this raised no concerns about the food.

Summary of recommendations

1. Managers should audit care plans on a regular basis to ensure the interventions are person centred, care plans are updated following evaluations to reflect any changes in the individuals care needs, and legal status and that patient participation is recorded.

2. Managers should put an audit system in place to ensure that all medication prescribed for patients who are subject to compulsion under the Mental Health Act is properly authorised.

3. Managers should put a system in place to ensure that where there is a proxy decision maker this is recorded and a copy of the powers are held in the patient's file.

Service response to recommendations

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

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

ALISON THOMSON
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 MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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