mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Balmore Ward, Leverndale Hospital, 510 Crookston Rd G53 7TU

Date of visit: 6 January 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. 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 carried out face-to-face.

Balmore Ward provides care for older people with an organic mental illness. The ward is subdivided into two self-contained units with eight beds in one ward and ten beds in the other. Originally these were designated as single-sex units. However, to enable the service to respond flexibly to current service demands, one unit is operating as a mixed-sex facility. On the day of our visit there were 15 patients in the ward. We were told that despite having empty beds, the ward had two patients boarded out. Due to the clinical needs of the current patient group, the ward was unable to provide single room accommodation to allow new admissions to isolate as per current guidance.

We last visited this service on 7 November 2019 and made no recommendations at that time.

On the day of this visit we wanted to look at care plans, activity provision and visiting arrangements. This is because we know that the pandemic has had a significant impact on activity provision and visiting.

Who we met with

We met with and/or reviewed the care and treatment of seven patients and spoke with two carers.

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

Commission visitors

Mary Hattie, Nursing Officer

Yvonne Bennett, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The ward is served by four consultants, each covering a geographical area. Multidisciplinary team meetings (MDT) are held weekly for each consultant. MDT meetings are attended by medical and nursing staff, pharmacy, occupational therapy, physiotherapy and psychology when required; care home liaison attend virtually via teams. The ward has an allocated liaison social worker who acts as the first point of call for referrals and attends MDT meetings via teams. Relatives are not currently invited to attend MDT reviews, however they are contacted by the medical staff to discuss their views. MDT reviews are recorded within the EMIS electronic recording system and provide information on decisions taken and agreed actions.

Input from other allied health professionals and specialist teams are available when required on a referral basis and there is no reported difficulty with access.

Currently the ward has two patients whose discharge has been delayed awaiting either appropriate placement or guardianship.

We found completed 'Getting to Know Me' forms in the patients' files we reviewed. However these contained varying levels of information, with some having little meaningful information about the individual's previous life. This is a document which contains information on an individual's needs, likes and dislikes, personal preferences and background, which enables staff to understand what is important to the individual and how best to provide person-centred care whilst they are in hospital or in a care setting. There was no evidence of fuller life story information being recorded. Given that the majority of the patients who are admitted to Balmore Ward will go on to long term care placements, it is important that this information is recorded and goes with them through their care journey.

The care plans we reviewed were not person-centred. They were often completed very soon after admission and, whilst there was evidence of regular evaluations, the care plans were not updated to reflect new information or changing needs. As a result care plans were missing important information gathered since admission and did not reflect patients' current care needs and interventions.

We reviewed the files of a number of patients who were prescribed 'as required' (PRN) medication for agitation. The care plans for the management of their stress and distress lacked person centred detail on the nature of their behaviours, the triggers and recommended management strategies and thresholds for use of PRN medication. Referring simply to the need to use distraction techniques, use "Newcastle model approach" or "use prn medication when appropriate". Despite there being regular care plan evaluations and a number of patients having completed Newcastle formulations on file, and/or ABC charts completed to identify potential triggers and management strategies for their distress, the care plans had not been updated to incorporate this information to provide a person centred plan. The Newcastle model is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge.

Where PRN medication had been administered, the entry in the chronological notes did not provide sufficient detail on the reasons for administration, what other strategies had been used, or the effectiveness or otherwise of the medication. Some patients were receiving PRN medication frequently, but there was no record of this having been highlighted to medical staff for a medication review.

Both the carers we spoke to were very positive about their experience, we heard that staff were very kind and caring and communication was good. Teleconferencing has been used to enable participation in reviews and both nursing and medical staff consult with carers appropriately and keep them up to date with any developments.

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 ensure that 'Getting to Know Me' documentation is completed as fully as possible and life history information is recorded and follows the patient when they move to a further care placement.

Recommendation 2:

Managers should ensure care plans are person centred and updated following evaluations to reflect changes to the patients' needs and the effectiveness of interventions.

Recommendation 3:

Managers should ensure that there is person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and should be regularly reviewed and updated.

Use of mental health and incapacity legislation

Where individuals had a power of attorney or guardianship granted under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), this was recorded in the notes, and a copy of the powers were held on file, or there were entries in the chronological notes confirming that a copy had been requested and was being followed up.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. All the patients whose care we reviewed lacked capacity to consent to treatment. In each case there was a completed s47 certificate and treatment plan and proxy decision makers or relatives had been consulted appropriately.

Twelve of the 15 patients on the ward on the day of the visit were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). We found copies of all the detention paperwork on the patients care files and in the electronic patient record.

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. Certificates authorising treatment (T2/3) under the Mental Health Act were in place where required and authorised all treatment prescribed.

Rights and restrictions

The ward door is locked and entry is via a buzzer or key fob system. There is a locked door policy and information on this is provided to families and other visitors.

We did hear that due to concerns relating to the Covid-19 Omicron variant new visiting restrictions have recently been implemented. In line with current guidance, visiting is restricted to one designated visitor per patient. Whilst the ward supports visiting from 10am to 8pm, only one visitor can be accommodated within each unit at a time. Therefore visits have to be pre-booked and are time limited.

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

There is dedicated occupational therapy and physiotherapy input. We were told that due to the nature of the patient group there is not a set activity programme and staff provide activities on an ad hoc basis. Due to the nature of patients' needs, most activities are on a one-to-one or very small group basis and include reminiscence, doll therapy, going for a walk in the garden, or simply having a chat. We saw staff engaging in activities during our visit.

The ward has a Reminiscence Interactive Therapy Activities system (RITA) which is a touch-screen system providing reminiscence resources. Including music, news reports of significant historical events, games, karaoke, and films.

We found activity care plans in the files we reviewed, however these were not person centred and did not incorporate information on the individuals previous hobbies or preferences from the 'Getting to Know Me' documentation. There is an activity file which is maintained by the occupational therapy staff, setting out the activities undertaken within the ward. However there was very little individual activity participation and outcome recorded within the chronological notes which we reviewed.

We were told that a patient activity co-ordinator has recently been appointed who will work across both Balmore and Banff Wards, and they will be commencing work in the next few days. We look forward to seeing the impact of the patient activity co-ordinator on our next visit.

Recommendation 4:

Managers should ensure that activity care plans are person centred reflecting the individual's preferences, interests and abilities and that activity participation is recorded and evaluated.

The physical environment

Each of the units comprises of a number of small dormitories and single bedrooms, all the bed areas have ensuite toilet facilities. Each unit has a pleasant sitting and dining area, the corridors are wide, bright and clean. The shared garden area is safe and dementia friendly, benches have been custom made to decrease the falls risks. We were told that the garden area is popular with patients and visitors alike. The environment is dementia friendly with good signage, and dementia friendly furniture throughout, however the décor is becoming tired and we noted that where flooring in the corridor had been repaired there was an obvious colour difference, which can cause difficulties for a patient population who may struggle with perceptual difficulties associated with dementia. The ward has retained the wellness chair which was previously being trialled. This is designed to provide relaxation and sooth agitation using movement and music.

Summary of recommendations

1. Managers should ensure that 'Getting to Know Me' documentation is completed as fully as possible and life history information is recorded and follows the patient when they move to a further care placement.

2. Managers should ensure care plans are person-centred and updated following evaluations to reflect changes to the patients' needs and the effectiveness of interventions.

3. Managers should ensure that there is person centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and should be regularly reviewed and updated.

4. Managers should ensure that activity care plans are person centred reflecting the individual's preferences, interests and abilities and that activity participation is recorded and evaluated.

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.

Suzanne McGuinness
Executive Director (Social Work)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.
The Commission visits people in a variety of settings.

The 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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