Mental Welfare Commission for Scotland

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

Date of visit: 8 November 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 where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. 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 10 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 the ward was almost at capacity. We were told that there had been some recent discharges that had created empty beds. However there were still three patients boarded out. As these patients were nearing discharge, it was agreed it would be in their best interests to remain in their current ward and be discharged from there rather than have an additional ward move for a short time.

We last visited this service on 6 January 2022, and made recommendations in relation to the need for person centred care planning and life history information. The response we received from the service was that these issues were being addressed and would be completed by October 2022.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how the service is developing its community links as restrictions ease.

Who we met with

We met with, and reviewed. the care of seven patients, five of whom we met with in person and two who we reviewed the care notes of. We also spoke with four relatives.

We spoke with the service manager, the senior charge nurse, the therapeutic activity nurse, physiotherapist and members of the nursing team.

Commission visitors

Margo Fyfe, senior manager (practitioners)

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

We spoke to four relatives who were very positive about the care and treatment being provided by the ward. “My husband is always clean and tidy when we visit and the ward is spotless”, “I like to cut my dad’s hair and this is never a problem, staff are welcoming and let me get on with it”. We heard that staff were very patient and kind in their interactions when patients were distressed and we were told that communication was good; “the doctor contacted us after he was admitted and spoke to us about his diagnosis and what might happen next”. We also heard that staff are very supportive of relatives and provide information on their loved ones diagnosis; “when we have a bad visit someone will come and sit with us, or walk us out at the end and spend time talking to us and reassuring us. We leave feeling much better”.

The multidisciplinary team

The ward is served by four consultants, each covering a geographical area, and has dedicated sessional input from a therapeutic activity nurse, occupational therapist, physiotherapist and psychologist. 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. 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 and both nursing and medical staff consult with carers appropriately and keep them up to date with any developments.

MDT reviews are recorded in the EMIS electronic recording system. These were brief and lacked information about the decisions that had been taken in relation to the patient’s future and any actions required.

Care planning

We found completed ‘Getting to Know Me’ forms in the patients’ files we reviewed. There was a good level of detail around the individual’s previous life, family contacts and individual preferences and hobbies.

The care plans we reviewed varied considerably in the level of person-centred information they contained. A small number of recently completed care plans did contain person-centred information about the individual’s needs, and the interventions required to meet these. However, the majority were completed promptly after admission with evidence of evaluations taking place, alongside meaningful, relevant chronological notes that provided information on the patient’s presentation and changing needs. However, the care plans were not updated to reflect this new information. As a result many of the care plans were missing important information gathered since admission and did not reflect patient’s 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 varied in the quality of information these contained. A number of these appeared to be a standard template which referred to the need to use distraction techniques, or “use prn

medication when appropriate". Where the patient had a Newcastle formulation completed this was referred to in the stress and distress care plan and a copy was attached. This contained detailed information on the individual triggers and management strategies to use with the patient. 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.

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:
Multidisciplinary review records should include a record of decisions made and actions required.

Recommendation 2:
Managers should ensure there is a regular audit of care plans to ensure that the interventions are person centred, and care plans are updated to incorporate information on changes in individual patient's needs and interventions following reviews.

Use of mental health and incapacity legislation

On the day of our visit, 11 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Copies of detention paperwork were on file.

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. T3 certificates authorising treatment under the Mental Health Act were in place where required and authorised all treatment prescribed.

Where individuals have granted a Power of Attorney (POA) or guardianship under the Adults with Incapacity (Scotland) 2000 Act (the AWI Act), a copy of the powers granted should be held in the patients care file and the proxy decision maker should be consulted appropriately. We found where there was a proxy, this was recorded and copies of the powers were available in the care files we reviewed.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found section 47 certificates in place for all patients that we reviewed and where a proxy decision maker was appointed they had been consulted.

Rights and restrictions

Balmore operates a locked door, commensurate with the level of risk identified with the patient group. There is a locked door policy and staff respond promptly to requests from visitors to enter and leave the ward. Staff use this as an opportunity to speak to visitors and to provide information and give relatives an opportunity to ask questions or raise concerns.

We were told that visiting continues to be arranged on a booking basis, due to the layout of the ward and the absence of a separate room which can be used for visiting. Relatives have been consulted and are happy with the current system and there have been no difficulties in accommodating the level of visits requested.

We noted that there was information on advocacy on the ward notice board and were advised that advocacy services are responsive when referrals are made; no one is currently accessing the service.

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, and since our last visit, a therapeutic activity nurse has taken up post, working across Balmore and Banff wards. Activity provision has significantly improved as a result of this appointment.

We were told that due to the nature of the patient group most activities happen on a one-to-one, or very small group basis, and the activity programme is kept flexible to meet the changing needs of the patient group and to capitalise on opportunities as they arise. Activities are tailored to meet individuals' interests, and mood at the time. This information is recorded in the 'Getting to Know Me' booklets completed by families. Activities such as quizzes, reminiscence work, music groups are often supported by the use of Reminiscence Interactive Therapy Activities system (RITA), and we heard that the occupational therapist utilises memory boxes from the local library. Patients also enjoy walking in the garden or helping with the planters.

The ward has also had adaptations made to enable the installation of activity tables; however it is unclear when this will happen. We look forward to seeing these in action on our next visit.

Therapet visits the ward, along with music in hospitals and the therapeutic activity nurse is also looking at other community resources that can be utilised. We heard from the physiotherapist that, whilst he could work with individual patients in the ward, group work with this patient group was difficult without a second person to assist. A business case for a physiotherapy assistant is being put forward and we look forward to hearing the outcome of this on our next visit. We saw staff engaging in a number of activities with individuals during our visit.

We found activity care plans in the files we reviewed, although these varied in quality, with more recent ones containing person-centred information taken from the patients' 'Getting to

know me' documentation. However, there remained a number of template care plans that offered no useful personal information. The information on activity participation recorded in the chronological notes provided clear details on the activity participation and the outcome of this for the patient.

The physical environment

The male unit comprises of a number of small dormitories and two single bedrooms; all the bed areas have en-suite toilet facilities. The female unit comprises of one small dormitory and six single rooms. Each unit has a pleasant sitting and dining area. However the male unit is considerably larger and benefits from a dining area that is separated from the sitting room; this is beneficial when undertaking activities or accommodating visitors. The female area, whilst bright and well lit, is considerably smaller and would benefit from having a quiet area away from the main sitting dining area.

We saw patients using a 'pacer'. It is utilised for patients who become agitated when prevented from walking, but who can become tired and at increased risk of falling. It enables them to continue to mobilise safely and to rest without falling. We heard that the ward is looking to obtain a second one of these as it has been found to be very useful in reducing falls and avoiding the need to restrict patients.

The corridors are wide, bright and clean. The shared garden area is safe and dementia-friendly, with benches that 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.

Summary of recommendations

Recommendation 1:
Multidisciplinary review records should include a record of decisions made and actions required.

Recommendation 2:
Managers should ensure there is a regular audit of care plans to ensure that the interventions are person centred, and care plans are updated to incorporate information on changes in individual patient's needs and interventions following reviews.

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.

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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