Mental Welfare Commission for Scotland

Report on announced visit to:

Balmore Ward, Leverndale Hospital, 510 Crookston Rd,

Glasgow G53 7TU

Date of visit: 7 November 2019

Where we visited

Balmore ward provides care for older people with an organic mental illness. The ward is subdivided into two self-contained single sex units with eight beds for women and 10 beds for men. On the day of our visit the ward had 16 patients, 12 of whom were detained under the mental health act. The ward was closed to admissions due to the very high level of enhanced observations and clinical activity, this situation was being reviewed daily.

On our previous visit we made recommendations relating to recording life history information, person centred care planning and activity, we recommended that information relating to patients legal status is properly recorded and available. We also recommended the environment be looked at with a view to making it more dementia friendly.

On this visit we will be following up on the previous recommendations.

Who we met with

We met with and or reviewed the care and treatment of eight residents and five relatives.

We spoke with the senior charge nurse and charge nurse and one of the consultants.

Commission visitors

Mary Hattie, Nursing officer

Anne Buchanan, Nursing officer

What people told us and what we found

Care, treatment, support and participation

The ward is served by five consultants, each covering a geographical patch. Multidisciplinary team meetings are held weekly for each consultant. These meetings are attended by medical and nursing staff, pharmacy, social work, occupational therapy, physiotherapy and psychology when required. Other allied health professionals and specialist teams are available on a referral basis and there is no reported difficulty with access.

We were told that the ward often ran a waiting list. We found evidence in the files of several patients having commenced their admission in wards in other sectors of the city, due to a lack of available beds, before being transferred to Balmore. The ward has an allocated liaison social worker who acts as the first point of call for referrals and attends multidisciplinary team meetings. We are advised this has been beneficial in improving communication and ensuring assessments are processed promptly. Currently the ward has two patients whose discharge has been delayed awaiting either appropriate placement or guardianship.

We had previously made a recommendation in relation to recording life history information as this is essential to the development of person centred are plans and the delivery of person centred care. We found Getting to Know Me forms in all the files we reviewed these contained varying levels of detail. The information these contained had been used in the development of person centred care plans. Given that the majority of the patients who are admitted to Balmore ward will go on to long term care placements, this is an area that would benefit from ongoing development.

Where individuals were receiving PRN medication for stress or distress, there was a stress and distress care plan in place giving information on triggers and person centred management, the level of detail these contained varied, with some exemplars of good practice and some requiring further development. We were advised by the senior charge nurse that care planning for the management of stress and distress is being continually improved and developed and were shown a newly developed format based on the Newcastle model which is being trialled in the ward at present.

There have been a number of drop in events for relatives and carers, and during our visit it was evident that every visitor is greeted and given an update on their relative on arrival and the opportunity to discuss any concerns. All of the relatives we spoke to were very positive about the care provided and told us communication with medical and nursing staff was excellent. However we were told by the senior charge nurse that the team are keen to develop this further, in future key workers will arrange to meet with relatives to discuss the patients care plan and obtain their input. This will be evidenced by relatives or proxies signing the care plan as agreed. We look forward to seeing this on our next visit.

Where there is no guardian or attorney for a person who cannot consent to a decision about cardio pulmonary resuscitation (CPR), it is a requirement to consult with the close family, as well as trying to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. In all the care files we reviewed which contained 'Do not attempt CPR' forms these were completed with evidence of discussion with nearest relative or proxy as appropriate.

The Commission has produced good practice guidance on person-centred care plans which can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Use of mental health and incapacity legislation

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the Adults with Incapacity (Scotland) 2000 legislation 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 section 47 certificate and treatment plan and proxy decision makers or relatives had been consulted appropriately.

Where individuals had granted a power of attorney this was recorded and a copy of the powers was held in their care file.

12 of the 15 patients on the ward on the day of the visit were detained under 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 MHA sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were all in order as appropriate.

Rights and restrictions

The doors to the unit are locked, access and exit is controlled via keypad. Staff are on hand and responded promptly to all requests to access or leave the ward during our visit.

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

Since our last visit the ward has benefited from an increase in occupational and physiotherapy provision, there is also a full time occupational therapy technician post, shared with another ward, dedicated to co-ordinating and providing recreational and therapeutic activities. Due to the nature of the patients' needs the technician does not run a fixed activity programme in Balmore ward, but provides activities in small groups or on an individual basis, such as reminiscence work, arts and crafts, board games, exercise and music, quizzes etc.

The ward has recently secured funding for the provision of a Tover Tafel (magic table), this is a piece of recreational equipment which can be used in a number of ways, with individuals or

small groups, to provide stimulation and increase engagement and communication. We look forward to seeing this in action on our next visit.

The ward has several iPads available, staff assist patients to keep in contact with relatives using Facetime, or use these as recreational equipment.

We found activity care plans, containing details of people's preferences and previous hobbies, in the files we reviewed. We saw patients engaging in activities throughout the visit and found some evidence of activity participation recorded in the chronological notes. However we are advised that the transfer of the chronological record to the electronic Emis system means staff have to take time away from the patient area to enter records and this has resulted in a decrease in the routine recording of activities. We are advised that management are aware of this and work is underway to address this issue. We look forward to seeing how this is implemented on our next visit.

The physical environment

Each of the units comprises of a number of small dormitories and single bedrooms, all the bed areas all have en suite 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. The garden was being used by patients during our visit, despite it being a cold autumn day.

Since our last visit the ward has benefited from several environmental improvements including the installation of coloured handrails and dementia friendly signage in the corridors, improvements to the toilets to make them more dementia friendly and the provision of new furniture, with contrasting colours, in the sitting rooms. We were also told that the ward had been trialling a Wellness chair, which is designed to provide relaxation and sooth agitation using movement and music. The results of this have been positive and a bid has been submitted to secure funding for two of these as a permanent addition to the ward.

Any other comments

We were advised by the senior charge nurse that some of the good practice developments which the ward had introduced, had been lost in the changeover to the Emis system. These included additional prompts added to the multidisciplinary meeting record form, and the use of a template, similar to the ones used to record prn medication, to record positive interventions which successfully de-escalated distressed behaviours. They have submitted these to the working group and are awaiting information on whether these can be incorporated into the Emis system. We look forward to seeing these in operation on our next visit.

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

MIKE DIAMOND

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 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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk