Mental Welfare Commission for Scotland

Report on announced visit to:

Banff Ward, Leverndale Hospital, Crookston Road, Glasgow G53 7TU

Date of visit: 2 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 that is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Banff ward is a 20-bedded unit divided into six single rooms and three dormitories. The unit provides assessment and treatment for older adults who have a functional mental illness.

We last visited this service on 3 November 2021, and made recommendations in relation to care planning, recording of proxy decision makers and authority to treat under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The response we received from the service was that all the recommendations made had been implemented, training sessions on care planning are ongoing and effectiveness of actions had been confirmed by audit.

We wanted to follow up on the previous recommendations and also to hear how the service was developing its community links as restrictions were eased.

On the day of this visit the ward was at full complement with four patients boarded out to other services. There were five patients requiring enhanced levels of observation. We heard that whilst the ward is fully establishment in terms of the nursing workforce, due to the continued high levels of clinical activity, there has been a need to use significant numbers of bank and agency staff.

There are fortnightly meetings with nursing, social work, commissioning and housing to manage patient flow. Currently the ward has one patient whose discharge from has been delayed.

Who we met with

We met with, and reviewed the care of seven patients, four who we met with in person and three who we reviewed the care notes of. We also spoke with one relative.

We spoke with the service manager, the senior charge nurse, physiotherapist and therapeutic activity nurse.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

What people told us and what we found

Care, treatment, support and participation

Throughout the visit we saw staff proactively interacting with patients in a kind and caring manner. Staff that we spoke with knew the patient group well. We were pleased to hear from the relative and the patients we met with that they were very positive about the staff, saying they were approachable and always had time for them.

Multidisciplinary team (MDT)

The ward has regular input from occupational therapy staff, physiotherapy, psychology and pharmacy staff as well as four psychiatrists, the nursing team and a therapeutic activity nurse, who has been appointed since our last visit. Other allied health professionals are available on a referral basis. The staff we spoke were very enthusiastic about the new developments in the ward, such as the wellbeing group, and the increase in activity provision. There is clearly a strong multidisciplinary ethos amongst the team who are motivated to continue to develop and expand the range of therapeutic activities provided to patients.

We heard that MDT meetings continue to happen face-to-face, with the option of joining virtually for community staff, if needed. The patient and their families are included in discharge planning or review meetings should they wish to attend. It was clear to see from these notes that when the patient is moving towards discharge, that community services also attend the meetings.

There are a number of therapeutic group activities being provided, including a weekly wellbeing group, which comprises of nine sessions and that has input from several members of the MDT team. This covers issues such as sleep, exercise, anxiety, diet, medication and relaxation. We heard that there have been two cycles of this group and patient satisfaction questionnaires are currently being analysed as staff endeavour to develop the groups further.

The psychologist leads on Newcastle formulation meetings fortnightly and has been providing training in lower level psychological therapies for staff. 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. There is a nurse champion for psychological therapies who is raising awareness of available training and resources and supervision.

Care records

Information on patients care and treatment is held in three ways; there is a paper file, the electronic record system EMIS and the electronic medication management system. Care plans, care plan reviews and information on proxy decision makers is held in the paper file, with all other information being held on EMIS. We were told that there are plans to incorporate care plans into the EMIS system and we heard that staff are looking forward to this.

We found clear detailed records of MDT reviews, with information on who attended, decisions taken, actions required, and patient and family involvement. Chronological notes were detailed, informative and relevant.

The nursing care plans we reviewed appeared to comprise mainly of standard template care plans, with an initial statement of need, containing relevant information relating to the patient. However the interventions recorded below were standard generic statements which took no account of the identified needs and personal information recorded. The care plan reviews were meaningful and informative, but the care plans were not being updated to incorporate this information relating to changes in patient need or presentation.

Recommendation 1:
Managers should provide support and training on person centred care planning. There should be 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 patients needs and interventions following reviews.

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

Use of mental health and incapacity legislation

On the day of our visit, 15 of the 20 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). All documentation relating to the Mental Health Act and Adults with Incapacity (Scotland) Act 2000 (AWI), including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date.

Part 16 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Where individuals have granted a Power of Attorney (POA) or are subject to guardianship under the Adults with Incapacity (Scotland) 2000 Act (the AWI Act), a copy of the powers granted should be held in the patient's care file and the proxy decision maker should be consulted appropriately. We found that there was lack of clarity around whether a POA had been appointed for one patient, and copies of the guardianship powers were not present in one patient's file.

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 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 we reviewed who lacked capacity and where a proxy decision maker was appointed, they had been consulted.

Recommendation 2:
Managers should ensure that staff have an understanding of the AWI act, in relation to proxy decision makers and should ensure that where a proxy decision maker this is recorded and a copy of the powers are held in the patient's file.

Rights and restrictions

We are advised that the local advocacy service respond positively to referrals, and we saw evidence in the chronological notes that advocacy was actively involved with a number of the patients.

Banff ward continues to operate a locked door, commensurate with the level of risk identified with the patient group. There is a locked door policy and there was information on how to access or leave the ward on one of the notice boards.

The ward operates an open visiting policy.

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 regular input from occupational therapy staff and the physiotherapist who attend several days each week and provide assessments, one-to-one therapeutic work, and small group based activities. Since our last visit, a therapeutic activities nurse has been appointed, who works across Balmore and Banff wards. We heard that occupational therapy staff and the activity nurse co-ordinate their plans to maximise availability of activities for all patients.

We heard that now that restrictions are lifting, the ward is once again benefiting from outside volunteers providing music sessions, and it is hoped that pet therapy will recommence soon. There is an activity board, which shows planned group activities for the week; this is updated each week in light of requests and suggestions arising from the patient group. During our visit we saw patients knitting, planning craft projects with the activity nurse, participation in small group activities, including an exercise class run by the physiotherapist, a quiz run by the activity nurse, and we saw staff spending time chatting with patients and engaging in one-to-one activities with them.

Activity participation and outcome is recorded in the chronological notes.

The activity nurse is keen to develop community links and support patients to engage with the community through use of local facilities, attendance at local tea dances, etc. This remains a

goal for the future as the ward does not currently have access to any patient transport and the high levels of clinical activity make it difficult for the nursing team to commit in advance to supporting off-ward activities. We look forward to seeing how this is taken forward during our next visit.

The physical environment

The ward has a spacious, bright dining area, shared with the rehabilitation unit next door, and a lounge as well as a large conservatory and a dedicated activity room which is well stocked with games, magazines, books and craft supplies. There is a therapeutic kitchen and patients have access to domestic laundry facilities within the ward. Sleeping accommodation is a mixture of en-suite single rooms and small dormitories. There is access to a small secure garden area which is used regularly by a number of patients.

Summary of recommendations

Recommendation 1:
Managers should provide support and training on person centred care planning. There should be 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 patients needs and interventions following reviews.

Recommendation 2:
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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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