Mental Welfare Commission for Scotland

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

Date of visit: 29 November 2023

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 in one ward and ten beds in the other.

On the day of our visit there were 18 patients in the ward, 15 of whom were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). We last visited this service in November 2022, and made recommendations in relation to care planning and documenting multidisciplinary team review decisions.

The response we received from the service confirmed the issues had been addressed.

On the day of this visit we wanted to follow up on the previous recommendations and also look at activity provision, as the opportunity to engage in meaningful activities and exercise are important to us all, and impact on quality of life.

Who we met with

We met with and/or reviewed the care and treatment of six patients. No relatives requested to meet with us or were present during the visit.

We spoke with the service manager, the senior charge nurse, the charge nurse, the physiotherapist, and the occupational therapist.

Commission visitors

Mary Hattie, nursing officer

Justin McNicholl, social work officer

What people told us and what we found

Care, treatment, support and participation

The ward is served by three 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 Microsoft Teams. Relatives can request to attend MDT reviews and are invited when key decisions are being considered. Where relatives do not attend reviews, 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.

On our previous visit we made a recommendation relating to the quality of information recorded. During this visit we found that the MDT reviews were much improved and contained information on who was present, a summary of the patient's presentation and clear information about decisions made and actions required**.**

Care plans

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

During our previous visit, care plans were held in a paper file, whilst chronological notes and reviews were held on the EMIS electronic recording system. We made a recommendation in our previous report that managers should ensure there was a regular audit of care plans to ensure that the interventions were person-centred, and care plans were updated to incorporate information on changes in individuals' needs and interventions following reviews.

Care plans are now held in the EMIS system. We were told that this transition had been supported by additional one-to-one training sessions from the practice development nurses and that staff found this beneficial. We also heard it is much easier to update care plans to reflect changing needs identified in reviews or chronological notes. The care plans we reviewed reflected the risks identified in the CRAFT risk assessment and contained detailed person-centred information about the individual's physical and mental health care needs and preferences, along with the interventions required to meet these. All of the care plans we saw were updated to reflect individuals' current needs.

We were pleased to see discharge plans being developed for all the individuals we reviewed, even those recently admitted.

We reviewed the files of a number of individuals who experienced stress and distress and were prescribed as required medication for this. We found very detailed Newcastle formulations completed for these people and there were care plans for managing their stress and distress which referenced this information and contained detailed information on the individual triggers and management strategies to use with the individual. 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.

We also saw the 'flashcards' that had been developed to support new and unfamiliar staff when interacting with individuals who experience stress and distress. These summarised key information which staff needed to know in order to explain how best to manage that individual's care safely and well.

We were told that nursing staff and the psychologist meet weekly to discuss anyone requiring Newcastle formulations. Previously these would have been completed by the psychologist and the nursing staff would have developed the care plan from this, however as staff develop greater expertise in this area, nurses are becoming involved in the development of the formulation, with a view to leading on these in the future, with supervision from the psychologist.

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

Delayed discharges

On the day of our visit there were five delayed discharges. These were due to a lack of availability in suitable placements to meet the individual's needs. Three people were waiting for NHS complex care. A new service is being commissioned to provide complex care beds; it is anticipated that this will become operational in February 2024, and will provide the resource necessary to significantly ease pressure on admission beds.

Use of mental health and incapacity legislation

On the day of our visit, 15 patients in the ward were detained under the Mental Health Act. Copies of detention paperwork were on file.

Part 16 (sections 235 to 248) of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, 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. We found that one person was prescribed a medication which was not authorised on their T3, however the medication had not been administered. This was brought to the attention of the SCN, who will refer this to the consultant for action.

Where individuals had granted a power of attorney (POA) or where there was a guardianship order in place, under the Adults with Incapacity (Scotland) 2000 Act (the AWI Act), a copy of the powers granted should be held in the individual's 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, or for recently admitted patients it was confirmed these had been requested and were being followed up.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate 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 s47 certificates in place for all individuals that we reviewed, and where a proxy decision maker was appointed, they had been consulted.

For people who had covert medication in place, the Commission's covert medication pathway was completed and all appropriate documentation providing legal authority was in order. The Commission has produced good practice guidance on the use of covert medication at: https://www.mwcscot.org.uk/node/492

Recommendation 1:
Medical staff should ensure that, where a T3 certificate is required, all medication prescribed is appropriately authorised on this**.**

Rights and restrictions

Balmore Ward operates a locked door, commensurate with the level of risk identified with the group. There was 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, to provide information and give relatives an opportunity to ask questions or raise concerns.

We were told that open visiting has recommenced, and person-centred visiting, in line with NHS Greater Glasgow and Clyde guidance, is in place; there has been a request for posters to be put up to advertise this fact. We were told that there are plans to develop a family-friendly visiting area to improve the visiting experience for families; individuals often look forward to visits by grandchildren and the ward is keen to make this as positive an experience for everyone as they can.

The ward reception area has a number of information boards and stands, providing helpful information, including information on local carer's services, a copy of the dementia standards and a wide range of relevant health information leaflets. There was also a prominently displayed suggestions box, with paper and pens available and a "you said, we did" board, showing actions taken as a result of individuals' and carers' suggestions. Information on advocacy was prominently displayed and it was advised that advocacy services are responsive when referrals are made.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that people 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 a dedicated therapeutic activity nurse, occupational therapy, and physiotherapy input across Balmore and Banff Wards. Activity provision has significantly improved. We were told that due to the nature of the group, most activities happen on an individual or very small group basis, and the activity programme is kept flexible to meet the changing needs of the 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, and music groups have been supported by using Reminiscence Interactive Therapy Activities system (RITA), however the contract for this equipment is due for renewal. Given the cost and the fact that technology has recently developed considerably, the ward has decided not to renew, but instead to invest in a variety of technologies, including iPads and smart TVs, which will enable the ward to access a wide variety of resources, including streamed dementia-friendly ballet, opera and theatre performances from the Glasgow Royal Concert Hall. The ward had adaptations made to enable the installation of activity tables; however, this is no longer an option.

We heard that the ward has been successful in making a bid for funding to further enhance the activity resources available and will be purchasing sensory equipment and a number of dementia friendly games which will increase the variety of activities that can be offered. We also heard that consideration is being given to creating a second activity nurse post, to provide an activity nurse presence full time in both Balmore and Banff Wards.

Individuals also enjoy walking in the garden or helping with the planters. Therapet visits the ward, along with Music in Hospitals & Care, and the therapeutic activity nurse is also looking at other community resources that can be utilised. We heard that where it is appropriate, people can access the on-site activity centre and participate in groups such as the pottery group in Banff Ward. We heard from the physiotherapist that while she works with individuals in the ward, group work was difficult. The activity nurse runs exercise groups and there are plans for this to be supported by physiotherapy as resources become available.

We found activity care plans in the files we reviewed containing person-centred information taken from the 'Getting to Know Me' documentation. The information on activity participation was recorded in the chronological notes and provided clear details on the activity participation and the outcome of this.

The physical environment

The ward is entered via a reception area where information is displayed. There is a multidisciplinary room off the reception; we heard about the plans to upgrade this room to allow it to function as a family-friendly visiting area.

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, while bright and well lit, is considerably smaller and would benefit from having a quiet area away from the main sitting dining area.

Whilst these are two discrete areas separated by a door operated by a swipe card, this door can be opened for periods during the day to enable people to move between the two areas if this is felt to be safe and beneficial to people at the time. 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 and high-level planters are dotted around for ease of access to the older patient group. We were told that the garden area is popular with individuals and visitors alike, and that new garden furniture and robust gazebos have been ordered to enable the space to be utilised more frequently, given the vagaries of the Scottish weather. The ward environment is dementia-friendly with good signage and dementia-friendly furniture throughout, and we were told that new furniture is on order for the dining areas.

We saw that en-suite bathroom doors had been replaced with anti-ligature plastic partial doors, which are held in place by magnets. We are aware of concerns regarding the impact on people's privacy and dignity with these screens in place and the potential falls risk, especially in units caring for elderly confused people, should they attempt to use these for support. We were pleased to hear that the ward staff had raised their concerns and been listened to, and an alternative solution is being considered with a more robust door being produced for trial in the ward. We look forward to hearing the outcome of this.

Summary of recommendations

Recommendation 1:
Medical staff should ensure that, where a T3 certificate is required, all medication prescribed is appropriately authorised on this.

Good practice

Considerable work has been undertaken to improve the standard of care planning since our last visit and the staff should be commended for this. We were particularly impressed with the ongoing work around management of stress and distress, particularly around the development of the flashcards. Considerable thought had gone into this development. We felt this novel development was an exemplar of good practice which could be shared with other areas.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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