Mental Welfare Commission for Scotland

Report on unannounced visit to:

Balloch Ward, Leverndale Hospital, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 21 March 2017

Where we visited

Balloch is a 20 bedded mixed sex ward for patients who require longer term rehabilitation. At times of full occupancy in the acute wards, if there is capacity in Balloch a small number of beds can be utilised as part of contingency planning. Patients who have passed the acute phase of their illness and are awaiting discharge from the acute adult wards can be transferred on a short term basis to avoid boarding patients out to other hospitals. These patients continue to receive their MDT care by their own clinical team and should return to their locality ward as a priority for the next available bed.

Patients have complex mental health difficulties, physical health issues and problems with motivation and sustaining engagement with rehabilitation. Some have been in hospital for many years, others have had multiple admissions and community placements have broken down. On the day of our visit there were 17 patients in the ward and one patient who had been transferred to a general hospital due to physical health problems and was being supported there by Balloch staff.

We last visited this service in February 2016. At that time there were concerns about the amount of occupational therapy (OT), patient activity coordinator (PAC), psychology and psychiatry time, which impacted on patient care. We also made recommendations about the programme of activities to promote rehabilitation, the use of activity planners, the integration of input from the recreational therapy department to the ward programme and the need to audit s47 incapacity certificates under the Adults with Incapacity Act (AWI).

Our reasons for visiting on this occasion were to see whether the recommendations from our last visit had been implemented.

We also looked at:

- Care and treatment and service user participation
- Use of legislation
- Therapeutic activity
- Physical environment

Who we met with

We met with six patients, looked at their records and those of one other person and spoke to the staff on duty.

Commission visitors

Alison Goodwin Social Work Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

In our last report we commented on the diverse group of patients in the ward. Many patients have been in hospital for a considerable number of years and the chronic nature of their illness means their motivation and ability to engage and participate in activities of daily living, therapeutic, social and recreational activities is limited. Their understanding of the rehabilitation programme and the details and purpose of the therapeutic input is poor.

This has not changed since our last visit. There are a number of patients in the ward whose needs are more appropriate to a continuing care or other setting rather than a rehabilitation setting. The combination of patients impacts considerably on the function of the ward as part of a rehabilitation service, makes it very difficult for staff to maintain a rehabilitation focus and limits the progress of patients who may be more able to benefit from longer term rehabilitation. We consider that there needs to be an urgent review of the function of the ward as an effective part of the rehabilitation service.

The patients we spoke to did not raise any specific concerns about the ward and were generally positive about their interactions with staff. However, on the day of our unannounced visit, the complement of staff was reduced due to sickness. We were told that staff are often taken away to staff other wards, which will limit the ability of the staff group to follow through rehabilitative programmes. There was one person on special observation and one on constant observation, as well as the use of enhanced observations for several patients for specifically prescribed activity. **The staffing within Balloch is adequate for the patient setting. It is acknowledged that in extreme circumstances staff may be deployed throughout the hospital. Observation levels, both within Balloch and off site, do have an added impact.

Some of the care plans are person-centred and detailed, and it was clear they had been evaluated and reviewed and the date of review recorded on the care plan. Others were more formulaic and lacked detail, particularly of interventions with regard to managing aggressive behaviour. Some did not record if they had been reviewed. There were good OT assessments in the records but it was not evident that the recommendations from these assessments were carried through to the nursing care plans. There were good nursing reviews using the SBAR model (situation, background, assessment, recommendations).

We were pleased to see that there are regular reviews of care and treatment plans, some of which are recorded in the multidisciplinary team (MDT) paperwork and some in the chronological notes. We heard on our last visit that there were plans to use a new MDT process sheet which would be more robust in reflecting patient and carer views. We saw this new paperwork but felt it was poorly completed. It did not

record patient or carer views or attendance at the meetings or the action points from the meeting. We were told that nursing staff did not find the new paperwork useful.

Although all patients are offered the opportunity of attending the MDT meetings, most declined to do so. Their issues and views are fed in and there is feedback from the meeting by nursing staff. We were told there is good advocacy input available to patients with regard to support at mental health tribunals though many patients decline this service. There was previously a weekly patient meeting in the ward but this no longer seems to happen. There were 'My Views' forms which reflected patients' views on their care and treatment in some of the files but these were several years old and we were told this means of gathering patients' views was no longer used.

We heard there is input to the MDT from pharmacy and on referral from speech and language therapy (SALT), dietetics, physiotherapy and psychology. We felt more psychology input could assist with the challenges of some of the people we saw in terms of engagement and motivation, and that a positive behaviour support plan for the patient with a learning disability would be useful for staff. There was input from OT to complete functional assessments and four sessions for activities of daily living (ADL) such as shopping, breakfast and lunch groups. There are two sessions from the PAC nurse, a session from the physiotherapist and two sessions from recreational therapy (RT). There is good recording in the chronological notes from all the allied health professionals.

The specialist registrar provides ongoing physical health care along with the duty doctor on site. All patients have an annual health check and there is good follow up of any physical health issues arising from this, as well as on an ongoing basis.

Recommendation 1:

The service manager should review the ability of the ward to carry out its function as a medium term rehabilitation ward. This should include reviewing the criteria for admission, the reassessment of the suitability of each patient for rehabilitation, and plans for progressing more suitable placements for those who do not fit the criteria for the ward.

Recommendation 2:

The charge nurse should audit the care plans to ensure they are person-centred, interventions are sufficiently detailed and that they are inclusive of the recommendations of the OT assessments.

Recommendation 3:

The MDT should consider whether there are other patients who would benefit from the input of the clinical psychologist.

Recommendation 4:

The service manager should consider how they gather patients' views and encourage greater patient participation in their care and treatment.

Use of mental health and incapacity legislation

The medication being given was covered by the consent to treatment forms (T2) and forms authorising treatment (T3) under the Mental Health Act (MHA).

Of the records we examined, we saw one out of date s47 certificate and one for an informal patient who appeared to lack capacity to consent to any of his treatment but whose s47 certificate only covered his physical health treatments. We did not see any treatment plans attached to certificates.

It would be useful for the medical staff to review all the patients on the ward in relation to their capacity to consent to treatment under AWI Act, and ensure s47 certificates and treatment plans, where required, as well as consent forms under the MHA, are completed and kept with the medication charts.

There are good personal spending plans for those patients whose funds are managed under Part 4 of the AWI Act.

Recommendation 5:

The service manager should ensure an audit of the need for certificates of incapacity and treatment plans under the AWI Act and ensure these and consent to treatment forms under the MHA are available with the medication charts, so staff are clear under what authority they are administering medication.

Activity and occupation

Patients do not have up to date individual weekly activity planners, though there were some in files which were a year or so old and did not reflect what people were currently doing. Without going through the chronological notes, it was difficult to establish the therapeutic, social and recreational activities that the person was engaged in or see the structure to their week.

We saw nursing care plans which indicated personal hygiene and self-care skills that nurses were working on with some patients. There is a ward weekly planner on the wall which indicates input from OT, PAC nurses, RT and physiotherapy. The chronological notes record if an individual has participated in activities of daily living (ADLs) as part of an OT cooking, breakfast or lunch group or one to one activity, or participated with PAC, RT or physio input on an individual or group basis.

Nursing staff arrange some social and recreational activities in the evenings and at weekends and also support some ADL activities. However, we considered that there

was much more that could be done to build on the skills of those with some prospect of rehabilitation. None of the patients in the ward do their own laundry. Some previously did this but no longer do as there is no washing machine in the ward. All laundry is done for patients. We heard that nursing staff change the beds and very few patients even make their beds in the morning. This is not appropriate in a rehabilitation setting.

There is a pool table in the activity room but we were told this is rarely used. This is not surprising as the area around the table is being used to store wheelchairs. Another patient who enjoys watching DVDs told us both DVD players in the room are broken.

Recommendation 6:

The service needs to ensure each patient has an individual weekly planner that includes all the activities of daily living, therapeutic, social and recreational activities they are involved in.

Recommendation 7:

The service needs to build on patients' skills of daily living and, where appropriate, support their development in areas such as laundry and basic domestic tasks.

Recommendation 8:

The support from OT, PAC and other nursing staff should be reviewed to ensure patients have an adequate programme of activities to promote rehabilitation.

The physical environment

Patients all have single rooms and access to toilets and showers. We were concerned that one shower that has not been upgraded is a ligature-risk, along with blind fittings on the door of the 'quiet room' (previously the staff resource room). Some rooms - mainly those used by female patients - are personalised, whilst most of the male rooms are fairly bare. This appeared to be by choice.

The heating in the ward is inadequate and several patients in the ward complained of being cold at night in their bedrooms despite additional heaters being provided. There is a good OT training kitchen for cooking. The laundry room, however, has no washing machine and this is unacceptable in a rehabilitation setting.

The activity room is being used to store wheel chairs, which means it is difficult to use the pool table. Items stored in the treatment room make it difficult to access some of the medication cupboards.

Smoking is an issue in the ward. A number of patients will attempt to smoke in the toilets and bedrooms and it is difficult for staff to supervise this. The garden is covered in cigarette butts and litter despite a bin being provided. We were told staff have in the past swept and tidied it but no longer do this as it has not led to any improvement.

Recommendation 9:

The service should urgently assess for any ligature points in the ward. **The roller blind fitting has been removed. The shower is being assessed and advice taken on replacement.

Recommendation 10:

The service should ensure there is an adequate heating system in the ward.

Recommendation 11:

The service should provide a washing machine to encourage patients in activities of daily living. They should also address storage issues in the ward.

Recommendation 12:

The service should urgently address the issue of smoking in the ward, repair the damage to toilet areas and ensure the garden is maintained as a recreational space that all patients can benefit from.

Summary of recommendations

1. The service manager should review the ability of the ward to carry out its function as a medium term rehabilitation ward. This should include reviewing the criteria for admission, the reassessment of the suitability of each patient for rehabilitation and plans for progressing more suitable placements for those who do not fit the criteria for the ward.

2. The service manager should ensure that care plans are audited to ensure they are person-centred, interventions are sufficiently detailed and that they are inclusive of the recommendations of the OT assessments.

3. The multidisciplinary team should consider whether there are other patients who would benefit from the input of the clinical psychologist.

4. The service manager should consider how they gather patients' views and encourage greater patient participation in their care and treatment.

5. The service manager should audit the need for certificates of incapacity and treatment plans under the AWI Act and ensure these and consent to treatment

forms under the MHA are available with the medication charts, so staff are clear under what authority they are administering medication.

6. The service manager should ensure each patient has an individual weekly planner that includes all the activities of daily living, therapeutic, social and recreational activities they are involved in.

7. The service needs to build on patients' skills of daily living and, where appropriate, support their development in areas such as laundry and basic domestic tasks.

8. The service manager should review the support from OT, PAC and other nursing staff should be reviewed to ensure patients have an adequate programme of activities to promote rehabilitation.

9. The service manager should arrange for urgent assessment of any ligature points in the ward.

10. The service manager should ensure there is an adequate heating system in the ward.

11. The service manager should provide a washing machine to encourage patients in activities of daily living. They should also address storage issues in the ward.

12. The service manager should urgently address the issue of smoking in the ward, repair the damage to toilet areas and ensure the garden is maintained as a recreational space that all patients can benefit from.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report except for recommendation nine which should be addressed within one month.

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

Alison Thomson
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 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.

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