Mental Welfare Commission for Scotland

Report on announced visit to:
Leverndale Hospital, Balmore and Banff Wards, Crookston Road, Glasgow, G53 7TU

Date of visit: 13 February 2025

Where we visited

Balmore Ward is an 18-bedded ward which provides care for older people with an organic mental illness. The ward is divided into two self-contained single sex units, one with eight beds and the other which has 10 beds.

Banff Ward is a 20-bedded mixed-sex ward, with six single rooms and three dormitories. The unit provides assessment and treatment for older adults who have a functional mental illness.

On the day of our visit, there were 17 people in Banff Ward and Balmore Ward was at capacity, with no vacant beds. Together, Balmore and Banff Wards provide the older adult mental health admission facilities for south Glasgow.

We last visited this service in November and December 2023 on an announced visit and made recommendations on risk assessments and care planning, catering provision and the physical environment. The response we received from the service was that recommendations in relation to care planning, risk assessment and catering were being addressed. The recommendation in relation to the physical environment was difficult to make progress on due to financial and physical constraints, however the pending review of older adults mental health services, which is still underway, will look at these issues.

On the day of this visit, we wanted to follow up on the previous recommendations and look at relative and carer involvement in multidisciplinary team (MDT) meetings.

Who we met with

We met with and reviewed the care of 12 people, 10 who we met with in person and two who we reviewed the care notes for. We also spoke with six relatives.

We spoke with the service manager, the senior charge nurses and members of the nursing team.

Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing officer

Anne Craig, social work officer

Gemma Maguire, social work officer

What people told us and what we found

The patients we spoke with were very positive about their experience of care. We were told “staff are fantastic” and “I have never had a bad day in here”. We heard that staff were always available to talk and were very kind and supportive. Throughout the visit, staff were visible in the ward and actively engaged with patients.

We heard from relatives that “I can speak to any of the staff; they are all great” and “the care couldn’t be better, even if we paid for it”. We were advised that nursing staff were always welcoming and readily available to update relatives whenever they visited. We saw staff meeting with relatives on arrival at the wards to advise them of recent issues, however one relative did advise us that communication had not always been good. We discussed this issue with the senior charge nurse on the day of the visit.

Care, treatment, support, and participation

Care records

In the care records we reviewed we found meaningful and relevant chronological notes. One-to-one sessions with staff were clearly recorded and “Getting to Know Me” (GTKM) documentation was in place in the records we reviewed. GTKM is a summary of information about the individual’s life and preferences which helps staff understand the person’s needs and ensures that the care that is delivered is person-centred.

Both wards are now using the new electronic care plan system which has recently gone live. This system now allows for care plan reviews to be added, and the care plans updated to reflect changes; the system can now support meaningful, dynamic care planning. We could see that the introduction of the care plan template has already made a significant improvement to the quality of the care plans. All the plans we reviewed were person-centred, reviewed regularly and updated to reflect changes in a person’s presentation and needs.

We found up-to-date CRAFT risk assessments and, where appropriate, Newcastle formulations, a framework and process developed to help nursing and care staff understand and improve their care for people who may present with behaviors that challenge. We heard of one individual where staff are using a “simulated presence” by means of a video of their relative speaking directly to them. They advise this has been a helpful addition to the strategies for reducing the individual’s distress.

During our previous visit to Balmore Ward, we were shown flash cards that staff had developed based on Newcastle formulations of the individual; these were designed to provide readily accessible information to assist staff. This has been further developed and adopted by both wards as “5 things that matter to me” which provides a one-page summary of individual needs and suggests personalised

management strategies for avoiding or de-escalating distress. This, alongside “What matters to Me” and GTKM provides a comprehensive framework for the delivery of person-centred care.

Several of the patients we reviewed had physical co-morbidities and we found that physical health needs were documented and considered in the care records.

Multidisciplinary team (MDT)
The wards are served by three consultants, each covering a geographical area, and have dedicated sessional input from a therapeutic activity nurse, occupational therapist, physiotherapist and psychologist. We heard there are plans to increase the activity nurse provision over the coming months. There is regular input from pharmacy and other allied health professions and specialist services are available on a referral basis.

There is an allocated liaison social worker who acts as the first point of call for referrals. 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 to keep them up to date with any developments.

There are currently 11 people across both wards whose discharge is delayed from hospital. Difficulties in finding suitable placements and delays in the guardianship process have contributed to this. We heard that a new delayed discharge team is now in place and is fully operational. It is expected that this proactive approach to managing discharges that are delayed will result in a reduction in these in the near future.

Use of mental health and incapacity legislation

On the day of the visit, 18 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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.

In relation to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), where the person had granted a power of attorney (POA) or was subject to a guardianship order, copies of the powers were available in all the files we reviewed. There was evidence throughout the chronological notes and in the MDT minutes of consultation with proxy decision makers in relation to care and treatment.

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 s47 certificates in place for adults who required this, and proxy decision makers had been appropriately consulted.

For patients who were receiving covert medication, covert medication pathways were in place.

Rights and restrictions

Both wards continue to operate restricted entry, commensurate with the level of risk identified in the patient group. There was information on how to enter and exit the ward available near the doors in both wards. We saw staff responding promptly and greeting relatives on arrival. Both wards offer open, personalised visiting arrangements.

The reception area of Balmore Ward had information boards and stands, providing helpful information, signposting local carers' services, as well as a copy of the dementia standards and a wide range of relevant health information leaflets. There was also a prominently displayed suggestion box, with paper and pens available and a "you said, we did" board, showing actions taken as a result of individual and carers suggestions. Information on advocacy was clearly displayed.

Banff Ward had a notice board providing information on advocacy, chaplaincy services, carers' support groups and other resources available and providing information about the ward and the activities which were being provided.

The Commission has developed *Rights in Mind.*[1] 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.

Activity and occupation

The wards have input from a therapeutic activity nurse who provides a comprehensive activity programme; this is supplemented by ad hoc activity provision by the nursing team.

There were activities available throughout the day, including a variety of group and individual activities which people could choose to attend, such as relaxation groups, quizzes, pamper sessions, reminiscence, musical activities, crafts and games. There were a number of external activity providers involved, including volunteers who run craft groups, a visitor who brought in a selection of small animals, therapet sessions and Music in Hospitals.

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

We saw the output of some of the craft groups that patients had been involved in and we saw staff spending time chatting with patients and engaging in one-to-one activities with them. Activity participation and outcome was recorded in the chronological notes, and we found that both individual activities and small group involvement was recorded. Activity provision was informed by the information in the GTKM documentation and person's choice on the day.

The physical environment

In Banff Ward, there was a spacious, bright dining area, shared with the rehabilitation unit next door, as well as a lounge, a large conservatory and a dedicated activity room which was well stocked with games, magazines, books and craft supplies. There was a therapeutic kitchen, used by those in the ward and occupational therapy, as well as access to domestic laundry facilities in the ward. There was access to a small secure garden area which was used regularly.

Sleeping accommodation was a mixture of six single rooms and three small dormitories. Single rooms had en-suite toilet facilities, but did not have shower facilities. Dormitories had ensuite toilet and shower facilities and there was a shower and a bathroom off the main corridor. Staff told us that there could be pressure on the shower room in the morning.

In Balmore Ward, the male unit comprised of several small dormitories and two single bedrooms; all the bed areas have en-suite toilet facilities. The female unit comprised of one small dormitory and six single rooms. Each unit has a pleasant sitting and dining area. The male unit was considerably larger and benefitted from a dining area that was separated from the sitting room; this was beneficial when undertaking activities or accommodating visitors. The female area, while bright and well lit, was considerably smaller and would have benefitted from having a quiet area away from the main sitting dining area.

While these were two discrete areas separated by a door that were operated by a swipe card, this door could be opened for periods during the day to enable people to move between the two areas if it was felt to be safe and beneficial to people at the time. The corridors were wide, bright and clean. The shared garden area was dementia-friendly, and high-level planters were dotted around for ease of access for the older adult group. We were told that the garden area was popular with those in the ward and with visitors alike.

We noted that several of the en-suite bedrooms had anti-ligature doors in place. We heard that they can be a potential falls risk as people attempted to steady themselves on them and they were designed to be easily dislodged; because of this it can be difficult to keep them in place. This also meant that an individual's dignity and privacy could be compromised. We were pleased to hear that an alternative solution is being considered. We look forward to hearing the outcome of this.

We previously made a recommendation about the environment in Banff Ward not being fit for purpose and have commented on the limited space in Balmore Ward.

We are aware that the review of older adult mental health inpatient services is progressing. We are hopeful that this may address these issues and we look forward to receiving the recommendations from this later this year.

Summary of recommendations

No recommendations were made.

We would like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved.

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 an individual's care, treatment, and support are 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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