Mental Welfare Commission for Scotland

Report on unannounced visit to: Trystview, Bellsdyke Road Larbert, FK5 4WS

Date of visit: 18 February 2020

Where we visited

Trystview is a 20-bedded mental health ward for patients aged 18-65 years who require intermediate care of more intensive slow stream rehabilitation. Trystview also has access to three on-site supported living flats and four off-site independent flats for the purpose of assessment of independent living. Other wards on the Bellsdyke site have access to these flats. On the day of our visit, Trystview did not have any patients in the flats. We last visited this service on 22 February 2018 and made recommendations around care plans, environment, and involvement of allied health professionals in planning patients care.

On the day of this visit we wanted to follow up on the previous recommendations.

On the day of our visit there were 11 patients in the ward, and three patients were on pass as part of their transition towards discharge planning. Two patients were boarding from the acute wards.

Who we met with

Our visit on this occasion was unannounced so patients, relatives, and staff had no prior notification of our arrival so did not have the opportunity to plan for contact with, or arrange appointments with us. We met with and/or reviewed the care and treatment of six patients.

We spoke with interim senior charge nurse (SCN), clinical nurse manager, and ward staff.

Commission visitors

Tracey Ferguson, Social Work Officer

Margo Fyffe, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Patients that we spoke with told us that they were happy with the care and support that they were receiving. Patients told us about their involvement in their care planning process and of their participation at meetings. Patients told us about the wide range of activities that they participated in and enjoyed.

Care Partner is the electronic system that the ward uses to record and store patient information. We found detailed nursing assessments in place, along with risk assessment and risk management plans that were reviewed regularly.

We were told that two consultant psychiatrists cover the ward and we were told that multi-disciplinary team (MDT) meetings take place regular with CPA (care programme approach) meetings also being held at a minimum of six monthly. We saw from records that the MDT includes a wide range of professionals who provide input to the ward as part of the patient rehabilitation process. The ward has two part-time occupational therapists, who provide full time cover to the ward, providing assessment, community integration support and therapy based group activities as part of the patients care and treatment. Patients have access to physiotherapy and psychology input.

We were told that staff plan the MDT in advance to allow as many people involved in the patients care to attend. We saw minutes of the MDT and CPA meetings recorded in patients' files with clear actions and outcomes. It was clear from the minute who attended the meeting. It was not always clear from the minute who fed back to the patient, if they did not attend. We discussed this with managers on the day and felt that the record should clearly record who is responsible for the feedback to patient rather than record MDT.

Staff told us that pharmacy provide really good input to the ward and the wider MDT. We saw in patient records a clear account of physical health history, along with ongoing physical health monitoring and medication review for each patient. The SCN told us that the ward also has two nurse prescribers on site and keeps good checks on patients' medication.

We wanted to follow up our last visits recommendation in relation to care planning. We saw care plans that were detailed, person-centred, covering a wide range of individual needs, with clear interventions required to meet the need. We felt that some progress has been made since our last visit. However, there was variation in the standard across some files. Some care plans were not holistic, and did not cover all the needs of the patient. Given some patients had been on the ward for several years, we felt that the holistic needs of some patients were lacking in detail and detail in regards to interventions was not evident. We discussed this further with managers on the day. We saw that the information was in other documents in the patients file but this needed to be translated to the patient's care plan.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We saw recordings of one-to-one nursing contact with patients as per care plans, and if the patient declined the session it was recorded. From reviewing the files it was not always easy to find one-to-one recordings. We discussed this with managers on the day and felt that staff needed to have a consistent method of recording this one-to-one session on the care partner electronic system. Although we saw detailed daily recording accounts from nursing staff in the patient's file, we viewed some recorded entries by staff which were limited and meaningless. Some patient contact that we saw did not provide an update regarding the patient's health and wellbeing. Recording visible around the ward was not a good account.

The SCN told us that there were two patients in the ward that were boarding from the acute wards. We discussed this further with the SCN. We were told that patients from the acute wards were always given the opportunity to agree to a move and, if they did not agree, the move would not take place. We were told that transfers to the Bellsdyke wards are usually considered for patients where there is discharge planning in progress, or for patients who would benefit from rehabilitation prior to discharge back to community. We were told that the consultant psychiatrist from the acute wards still continued to be the appointed RMO for the patients care and treatment. We had a discussion with the SCN about this as we were aware from speaking to patients that this meant they had a different MDT day from the other patients on the ward and often had to go back to the acute ward for this meeting. Perhaps consideration needed to be given when is the best time for transfer of the patients RMO, particularly if a decision had been made that the patient was not returning to the acute setting.

We discussed delayed discharges, and it was good to hear that for three of the patients that were identified as being delayed, plans were in place for discharge. On the day of our visit the patients were on pass from the ward and the ward staff were maintaining contact with the placement provider. We were told that for patients who are on pass from the ward, a CPA meeting takes place three weeks into the transition, and at the six-week point where formal discharge is being considered. We felt this was good practice as part of the patient's transition to the community. From reviewing the files, we felt that there was active planning in place for other patients who were working towards discharge.

Recommendation 1:

Managers should review their audit processes to improve the quality of care plans and ensure that care plans are person-centred, reflect the holistic care needs of each patient, and identify clear interventions and care goals.

Recommendation 2:

Managers should ensure that nursing documentation complies with the Nursing and Midwifery Council Code, and professional standards of practice and behaviour for nurses, midwives and nursing associates.

Use of mental health and incapacity legislation

On the day of our visit 12 patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995. For each patients electronic file that we reviewed we saw up to date appropriate legal documentation.

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. Patients' electronic records contained the appropriate legal paperwork. The authorising treatment forms (T3 and T2) completed by the responsible medical officer to record consent or non-consent were all in order as appropriate.

Where a patient's finances were being managed under Part 4 of the Adults with Incapacity Act (Scotland) 2000 we saw the appropriate legal certificate in the patient's record.

Anyone who receives treatment under the Mental Health Act can choose someone to help protect their interests. That person is called a named person. Where patients wanted to nominate a named person we saw records of this in the patients file.

Where a patient had opted to make an advance statement we saw copies of this in the file. An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future.

Rights and restrictions

The ward operates an open door policy with risk assessment informing time out of the ward on an individual basis. On the day of our visit, six patients had been made a specified persons under the Mental Health Act. Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

From the files we reviewed, all the relevant paperwork was in patients' files with evidence of reasoned opinions and ongoing reviewing in accordance with appropriate timeframe. We had a further discussion with managers on the day about the timescale of review process for telephones.

Our specified persons good practice guidance is available on our website.

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

We were told that the ward has good links with the local advocacy service and the advocates attend the ward regularly and meet with patients. We heard that accessing advocacy for informal patients can be an issue however we were told that this was not an issue for patients currently on the ward however has been previously. The commission will look into this further with NHS Forth Valley.

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

Staff told us that each patient is given a copy of their individualised weekly timetable to keep in their room. Some patients we spoke with found this helpful as it enabled them to view their activities for each day. There was also an activity timetable displayed on the wall of the ward. From our last visit we wanted to review the recommendation around AHP role and care planning. We saw OT and physio assessments in place, along with community integration plans as part of the patient's rehabilitation plan. The ward has two part time occupational therapists who provide on-site groups, community groups, and one-to-one community integration support for patients. We were able to see from speaking with patients and undertaking files reviews, that activities are happening. The ward has access to a minibus from community activities such as bowling, swimming and cinema. There is an on-site gym and a timetable in place, where physiotherapy, and ward staff are trained to do gym sessions. Staff are introducing decider skills groups across the whole Bellsdyke site and the SCN was telling us that discussions are in place to look at developing other site wide groups based around social, educational and health promotion for patients, and supporting patients to access more community groups and they work towards discharge.

We felt that there has been progress in ensuring the AHP role is actively involved in the care planning process in relation to the patient's rehabilitation. It was also good to hear of further areas of development that are being considered for the AHP role across the Bellsdyke site.

The physical environment

The ward consists of four linked houses with six rooms in each house. Within each house there are two bathrooms for six patients to access. On the day of our visit one of the houses was not in use due to patient numbers. We wanted to follow up on the recommendations from our last visit. The bathrooms were clean, and we saw that the work had been carried out to address the previous issues. The SCN told us that there is an ongoing maintenance programme for the ward. The ward was bright and nicely-decorated, with patients personalising their rooms if they wished to. Part of the windows on the ward have been replaced however we were told that the work had to be put on hold as the firm who was replacing these went into administration. We were told that this work had to go out to tender again and that a company has now got the contract and work should start again soon.

The ward has access to the outside garden space. There were seated areas with potted plants and shrubs in the garden. Although it was during winter when we visited, the garden appeared to be kept in good order. We were told that once the better weather comes in that patients like to work in the garden.

Patients have access to the on-site laundry facilities in the ward and there is a scheduled rota in place. We were told that for patients who are working with the OT for either assessment

purposes or as part of their discharge planning, that they can access the kitchen facilities within Russel Park ward as there is no kitchen facilities in Trystview.

Any other comments

Since our last visit the senior staffing team at Trystview and across the Bellsdyke site has changed. We were told that some staff have been successful in gaining promoted post, which on one hand is positive however recognised that this has left wards without a stable leadership team. We were told that there are two vacant senior posts across the Bellsdyke site and there has been recent ongoing recruitment for these posts in order to provide stability to the staff and patients in the wards. We were told that interviews are taking place the following week, where it is hoped that a new senior team will be appointed across the Bellsdyke site.

Managers told us that the whole Bellsdkye site is currently being reviewed. A steering group has been set up and ongoing meetings have taken place to look at the future needs of the service and identify gaps across the Forth Valley area. We are interested to hear about the future recommendations for the site and will write to the managers for an update.

Summary of recommendations

1. Managers should review their audit processes to improve the quality of care plans and ensure that care plans are person-centred, reflect the holistic care needs of each patient, and identify clear interventions and care goals.

2. Managers should ensure that nursing documentation complies with the Nursing and Midwifery Council Code, and professional standards of practice and behaviour for nurses, midwives and nursing associates.

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.

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.

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