Mental Welfare Commission for Scotland

Report on announced visit to: Ward 3, Forth Valley Royal Hospital, Stirling Road, Larbert FK5 4WR

Date of visit: 15 March 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 which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Ward 3 is an adult acute mental health admission ward based in Forth Valley Royal Hospital. Prior to the Covid-19 pandemic this ward's capacity was 24 beds; however since 2020 the number of beds has reduced to 21. We were told that the nursing establishment has remained unchanged following the reduction in bed numbers. The ward has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, an activity co-ordinator, psychology staff and pharmacy staff. Referrals can be made to all other services as and when required.

We last visited this service on 22 October 2019 and made recommendations in relation to nursing documentation, including care plans, visiting arrangements and activities. While we noted there had been improvements in relation to these recommendations, we identified areas that still require some attention.

On the day of this visit we wanted to follow up on the previous recommendations and also hear how patients, staff and relatives have managed throughout the current pandemic.

Who we met with

We met with and reviewed the care and treatment of nine patients and spoke with three relatives.

Prior to the visit we met with the clinical nurse manager and senior charge nurse (SCN) via video call. On the day of the visit we spoke with a range of staff including the service manager, the SCN, the charge nurse, lead nurse, the clinical nurse manager, the head of mental health nursing and the activity co-ordinator. We also met the ward occupational therapist and pharmacist.

Commission visitors

Gillian Gibson, Nursing Officer

Tracey Ferguson, Social Work Officer

Graham Morgan, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

Feedback from the patients and relatives we spoke to was positive. This applied to all members of the MDT. They were complimentary in regard to the availability of staff, their attitude, care and compassion and their communication with patients and their relatives.

The reduction in bed numbers has allowed the senior charge nurse office to be located in the ward. The pharmacist and occupational therapist were also located in the ward and the consultant psychiatrists were in the immediate vicinity. This has supported the visibility of key members of the MDT.

The majority of patients we spoke to were aware of who their named nurse(s) were and engaged regularly in one-one activities. A few of the patients we spoke to felt that at times, bank and agency staff were unfamiliar with their care and treatment plans which had an impact on their ability to deliver the quality of care they wanted.

Staffing challenges were acknowledged by managers who are being proactive in their efforts to recruit staff to vacancies, but recognise this is an issue nationally. In the interim, the service is using bank staff and at times agency staff to ensure safe practice in the ward. We heard that where possible, regular bank staff were block booked for shifts to promote consistency and relationship building which enhances the quality of care provided.

We heard from patients that they have found lockdown restrictions difficult, particularly the requirement on occasion to self-isolate in their rooms when there has been an outbreak of Covid-19 on the ward. It was also reported that the dining room had been closed and patients were required to eat their food in their rooms. Managers recognised this challenge and were working closely with the infection control and prevention team to re-open the dining room.

We also received feedback regarding dietetic requirements and preferences and the availability of dietetic staff to support individuals. We provided this feedback to the management team on the day of our visit.

We were pleased to note that visiting arrangements were being supported, albeit through a booking system. Visiting currently takes place in several rooms available outwith the main body of the ward. All patients we spoke to were happy with this arrangement and felt this was preferable to having relatives and carers in the ward environment.

Nursing care plans

When we last visited the service we found some examples of detailed and person-centred care plans, however the standard was found to be variable. An audit tool has since been created and the senior nursing staff audit five case notes per week.

On this occasion we found consistent, detailed person centred care plans which addressed a range of care for mental health, physical health and the more general health and wellbeing for

each of the patients. We were able to see that the risk assessments link directly to the care plans which helped to inform risk management and positive risk taking opportunities.

When we reviewed the care plans' evidence of patient involvement, this was unclear. Although some patients told us they had been involved in care planning and this was recorded on their electronic care plan, some patients told us they had not been involved in care planning, were not given copies of their care plans and did not feel they were regularly involved in their reviews.

Recommendation 1:

Managers should ensure all patients are supported to be fully involved in creating person centred care plans and participate in regular reviews. All patients should be given a copy of their care plans. Evidence of patient involvement should be clearly documented in their notes, including a detailed account of any reasons a patient disagrees with the care plan or chooses not to be involved.

Multidisciplinary team (MDT)

There is a broad range of disciplines available to patients in the ward. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and update on their views. This also includes the patient, should they wish to attend. If patients choose not to attend MDT meetings the consultant psychiatrist will provide them with feedback following the meeting. Risk assessments are reviewed at the weekly MDT and updated accordingly. There are meetings held twice weekly with colleagues in the community mental health team to identify patients nearing discharge. This allows community services to attend discharge planning meetings.

Care records

Information on patients' care and treatment is held on the electronic system, Care Partner. We found this system relatively easy to navigate. It was clear to see where specific pieces of information were located on the system including mental health legislation. All staff involved in the patients care are able to input into this system which promotes continuity of care, communication and information sharing. Nursing staff did report however that this system is fully reliant on the internet server and there was no way of accessing or recording information should the server go down.

Use of mental health and incapacity legislation

On the day of our visit eight patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The patients we spoke to during our visit had a good understanding of their detained status and had been fully informed of their rights.

Of those patients subject to compulsory treatment, we reviewed the legal documentation available in their files. Paperwork relating to treatment under part 16 (s235-248) of the Mental

Health Act was in order. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were available.

When we are reviewing patient files we looked for copies of advanced statements. The term advanced statement refers to written statements made under ss274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements; however, on the day of our visit, we were not able to locate and advanced statements. The Commission supports advanced statements, as they are a way of ensuring that people with mental ill health are listened to and have their human rights respected. We would like to see evidence of the attempts made to engage in a discussion regarding advanced statements and the reason noted for any patient that does not have one.

Rights and restrictions

Ward 3 continues to operate an open door policy; however, the door to the mental health unit is locked and patient access to and from this area continues to be monitored by a staff member seated at the door noting who was coming and going from the ward, their expected time of return and what they were wearing at their time of leaving the ward.

On our previous visit we were told that agreement had been reached to move forward in designing an alternative reception area, architect drawings had been completed and building controls were due to start work in January 2020. On the day of our visit we were advised that this work continues to be held up at building control. We were disappointed to see this development has not progressed but understand that Covid-19 has had an impact on this work.

For patients on one-to-one continuous observations, we were pleased to see evidence that this was reviewed on a regular basis.

As stated in our last report, Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

We found that where restrictions were in place, the appropriate documentation was available in the file to authorise this.

We were informed that all patients detained under the Mental Health Act were referred to advocacy by ward staff. We were pleased to hear that advocacy services had resumed face-face visits

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

Ward 3 has a dedicated activity co-ordinator who works Monday to Friday 9am-5pm. There was evidence of an activity planner detailing one-to-one activities available on several noticeboards within the ward. Documentation in care notes evidenced that activities were taking place. An art therapist also attends the ward one day per week

There is a dedicated occupational therapist (OT) for the ward who provides assessment focused activities.

Since our last visit more staff have been trained to support patients in the ward gym, including the occupational therapist. This has enabled more access for patients who wish to use it. However, Covid-19 restrictions limit the amount of patients who can use this facility at any one time.

We are aware that during the pandemic restrictions, various group activities had to be put on hold and that some of the patient groups have struggled with this change to their routine. Patients also expressed frustration that structured activity was only provided Monday to Friday and although nursing staff try to facilitate quizzes and movie nights in the evenings and at weekends, shortfalls in staffing can prevent this from happening.

There was also concern raised that there is no identified time when activities are scheduled to take place, which can impact on patients being able to structure their day. Decider Skills was also identified as an activity rather than a therapeutic intervention.

As activities are currently taking place on a one-to-one basis, we would have hoped to see these being individualised, meaningful and person-centred. There were no means in place to identify patients individual likes, dislikes, hobbies and preferences which meant that activities offered tended to be generic.

It was also brought to our attention that materials in the ward tended to be old and not in good working condition

Recommendation 2:

Managers should ensure there is a structured, scheduled, meaningful activity programme is available to patients seven days per week.

The physical environment

The layout of the ward consists of 21 single room, half of which have en-suite facilities. There is a lounge area and a separate quiet area. Two of the rooms are available to support perinatal admissions and a small sitting area and a room to facilitate visits is available. The dining area is currently not being used due to Covid-19 restrictions.

The ward is bright and spacious and the lounge had comfortable seating available. The environment was generally clean and tidy and we were able to see where efforts have been made to soften the public rooms including tasteful art décor on the walls.

There is a private courtyard for the use of the patients in Ward 3 and although there is no grass, we could see efforts had been made to ensure this is well maintained. Gardening groups take place in spring and summer.

There is a kitchen available for patients to use with the support of occupational therapy staff and a laundry room with washing machines.

Any other comments

We were informed that there is a significant pressure on beds in the other adult acute admissions ward which has resulted in Ward 3 taking a number of out of sector patients. However, due to the proximity of the wards, consultant psychiatrist cover is maintained by the responsible medical officer for that patient.

Summary of recommendations

1. Managers should ensure all patients are supported to be fully involved in creating person centred care plans and participate in regular reviews. All patients should be given a copy of their care plans. Evidence of patient involvement should be clearly documented within their notes, including a detailed account of any reasons a patient disagrees with the care plan or chooses not to be involved.

2. Managers should ensure there is a structured, scheduled meaningful activity programme is available to patients seven days per week.

Good practice

We saw first-hand the positive influence the introduction of values management has had for staff and indirectly for patients. Staff and patient experience questionnaires have been introduced and are collected and collated weekly. Examples of improvement work includes an increase in the number of staff who feel supported in the ward, an increase in the number of staff who are provided with managerial supervision and the introduction of an MDT preparation form for patients. This supports patients to be more prepared for MDT meetings and record outcomes. We were impressed with the ongoing commitment to supporting a learning culture in the ward and MDT and the commitment to clinical supervision.

Service response to recommendations

The Commission requires a response to these recommendations within three months of receipt of this report.

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

Suzanne McGuiness
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 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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