Mental Welfare Commission for Scotland

Report on announced visit to: Ward1, Forth Valley Royal Hospital, Stirling Road, Larbert FK5 4WR

Date of visit: 19 April 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 during the pandemic where we have been able to conduct our visits face-to-face and other times when Commission visits have been mainly 'virtual visits'. This local visit was carried out face-to-face.

Ward 1 is an intensive psychiatric care unit (IPCU) based within Forth Valley Royal Hospital. An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation. IPCUs generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often distressed patients.

Prior to the Covid-19 pandemic the ward had capacity for 12 beds, however since 2020 the number of beds has reduced to six. The ward admits both male and female patients.

There is a multidisciplinary team (MDT) approach to care delivery which consist of nursing staff, a psychiatrist, occupational therapist (OT), and pharmacist. There is also sessional support from an activity co-ordinator and provisions have been made for regular input from psychology. Referrals can be made to all other services as and when required.

We last visited this service on 21 November 2019 and made recommendations in relation to care planning, OT provision and the specified person procedures.

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

Who we met with

On the day of our visit there were four patients in the ward. We reviewed the care and treatment of all four patients and spoke with two. We also met with one relative.

Prior to the visit we met with the clinical nurse manager and senior charge nurse via video call. On the day of the visit we spoke with a range of staff.

Commission visitors

Gillian Gibson, nursing officer

Alyson Paterson, social work officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit the ward appeared calm. Feedback from patients and relatives regarding staff in the ward was positive. We heard that staff are caring, they listen and patients feel respected.

We learned that there are experienced, consistent nursing staff in the ward. If there is a requirement to use bank staff to cover staffing shortfalls, there is a regular pool of staff that are used which promotes consistency in care delivery and minimises risk.

We heard that patients regularly engage in one-to-one activities with staff, however, we would expect to find details of these documented in care records and were unable to find little evidence to support this.

Relatives and carers are supported to visit patients with a room available immediately outside the main body of the ward. This is currently arranged via a booking system with one visitor permitted at any one time. Visits are supervised by staff for safety and security purposes.

Nursing care plans

When we last visited the service we made a recommendation regarding the need for improvement to nursing care plans, specifically that they should be person-centred, contain individualised information, reflect the holistic care needs of each person and identify clear interventions and care goals. We reviewed all care plans in place and were pleased to find these had improved and were more detailed and person-centred. They covered a range of mental and physical health care needs and were reviewed regularly. We were also pleased to find evidence of patient involvement; in cases where patients were not involved or disagreed with their care plan, a clear account of this was given. Care plans also linked directly to the MDT meetings which helped to provide a clear narrative of the patient's journey.

Multidisciplinary team (MDT)

The ward has a range of disciplines available to patients. MDT meetings take place weekly and are currently attended by nursing, medical, occupational therapy (OT) and pharmacy staff. We were pleased to hear that there is a commitment in place for a psychologist to regularly attend MDT meetings in the near future.

There is a comprehensive MDT meeting template which is used to provide a record of clinical discussion and outcomes. Risk assessments and care plans directly link to this template along with information in regard to the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) status, Adults with Incapacity (Scotland) 2000 Act and specified person information. This acts as a prompt for review, provides a detailed record and a good overview of care and treatment

Patient and/or their relative/carer are invited to attend MDT meetings with the option to support this via video link if they are unable to attend in person.

Care records

Information on patients care and treatment is held on the electronic system, Care Partner. We found this system easy to navigate. It was clear to see where specific pieces of information were located on the system including mental health legislation. We found that overall there was a good standard of record keeping. All staff involved in the patients care are able to input into this system which promotes continuity of care, communication and information sharing.

Use of mental health and incapacity legislation

On the day of our visit, all 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 we provided feedback to the management team on the day regarding the need to ensure that there are regular opportunities to review a patient's rights with them, should they be unable to comprehend these at the time of their admission to hospital/detention.

Of those patients subject to compulsory treatment, we reviewed the legal documentation available in their files. Paperwork relating to treatment under part 16 (ss235-248) 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, however there were medications prescribed that were not authorised on T3 certificates. These were rectified during our visit.

When we are reviewing patient files we look 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. 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 appreciate that patients in an IPCU may be too unwell to make an advanced statement during their stay but we would like to see further evidence of how awareness is raised, at attempts made to engage patients in a discussion regarding advanced statements and the reason noted for any patient that does not have one.

The Commission has developed advanced statement guidance, which can be found at: https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf

Rights and restrictions

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 the MHA and where restrictions are introduced, it is important that the principle of least restriction is applied.

On our previous visit we made a recommendation in relation to specified persons procedures and the requirement to ensure all relevant paperwork is completed and reviewed.

We were pleased to find that where restrictions were in place, the appropriate documentation was available in the file to authorise this. We were informed that work had been undertaken

with staff to support positive risk taking in relation to specified persons which had resulted in a positive culture shift within the ward.

We found that risk assessments were detailed, thorough and comprehensive. These were also reviewed and updated regularly at MDT meetings.

We were informed that all patients detained under the Mental Health Act were referred to advocacy by their mental health officer (MHO) and/or nursing 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 1 has input from an activity co-ordinator one session per week and an OT assistant for three hours per week. They also have an art therapist who attends one day per week and provides both art and music therapy. There is an activity room in the ward with some gym equipment and a pool table. Patients, if well enough can also be escorted to a shared gym out with the ward.

We heard that nursing staff tend to provide a lot of the activity on the ward due to the higher staffing levels and we saw that there was an activity planner in place, however, it was not clearly documented in case notes what is being offered and/or delivered. We would advise that a record of activities, and the patient's participation, or not, is kept in the care record.

The physical environment

The ward is bright and spacious and the lounge had comfortable seating available. There was a separate dining area used for meals. Patients have access to an enclosed garden which was well maintained. The garden area would benefit from additional lighting to allow patients to use this safely in the evenings.

We heard that a proposal has been submitted in relation to the six bedrooms that are no longer in use. This would include plans to enhance the therapeutic environment and to create additional space in the ward. The feedback from patients that we spoke with indicated that their preference was for a designated gym specifically for patients in IPCU.

Good practice

The ward has introduced the use of the Brøset Violence Checklist (BVC). This is a six-item checklist, which assists in the prediction and prevention of imminent violent behaviour. This checklist is underpinned by research and can support improvement in therapeutic engagement and reduce the use of restrictive measures such as restraint and seclusion.

We saw that this was completed every shift and where scores indicated, an SBAR (situation, background, assessment and recommendation) report was completed which informed a clinical pause where intervention was determined and agreed. We were impressed to hear that this has resulted in a reduction in the average length of stay in the ward.

Summary of recommendations

There were no recommendations for the service to respond to in this report.

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

Suzanne McGuinness
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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