Mental Welfare Commission for Scotland

Report on announced visit to: Ward 2, Forth Valley Royal Hospital, Ward 2, Stirling Road, Larbert, FK5 4WR

Date of visit: 29 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 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 visit was carried out face-to-face.

Ward 2 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 18 beds, however since 2020 the number of beds has increased to 20. 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. On this visit, we were pleased to note that there had been improvements in relation to these recommendations, although we identified areas that still required some attention.

On the day of this visit we also wanted to 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 eight patients and spoke with two relatives.

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 clinical staff.

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

Almost everyone that we met with spoke positively about the staff in the ward. We heard how they are patient, caring, understanding and they listened. Patients told us they felt safe in the ward. However, we were consistently told that there were not enough staff, that they always seemed to be busy and that time out of the ward could often not be facilitated due to staffing pressures.

We were aware of the high acuity and diversity of patients in the ward at the time of our visit and the impact that this has on both staff and patients, particularly when there are patients on continuous one-to-one observations.

Staffing challenges were acknowledged by managers, who are being proactive in their efforts to recruit to the current 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.

The majority of patients we spoke to were aware of who their named nurse(s) were and engaged in one-to-one activities. There was good evidence in care records to support that one-to-ones were taking place but we found some variability in frequency and detail of recordings.

We heard from patients that lockdown restrictions have not been easy, particularly when on occasion there has been a requirement to self-isolate in their rooms on admission or when there has been an outbreak on the ward. These times were described as difficult and lonely. Relatives also spoke about the impact this has had on family involvement in care decisions and carer support. We were pleased to hear how staff have endeavoured to keep relatives and carers updated via telephone and that visiting arrangements continue to be supported, albeit through a booking system. Visiting currently takes place in several rooms available out with the main body of the ward.

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 found reasonable evidence of patient participation in care plans or recorded reasons as to why they were not involved

We were pleased to see that input and support had been sought from other nursing specialities like learning disability and autism to enhance care delivery to meet specific patient needs.

There were detailed risk assessments in place which were updated weekly following the MDT meetings and 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.

Multidisciplinary team (MDT)

The ward has a broad range of disciplines available to support patient care. It was clear from the detailed and consistent 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 and their relative/carer should they wish to attend. If patients choose not to attend MDT meetings the consultant psychiatrist would provide them with feedback following the meeting.

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 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.

Use of mental health and incapacity legislation

On the day of our visit fourteen patients were subject to formal measures 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 formal status and had been informed of their rights.

Of those patients subject to the Mental Health Act, 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 was a medication that was not authorised on a T3 certificate. This medication had not been administered and was immediately discontinued by medical staff.

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, and we were pleased to find one advanced statement in place on the day of our visit and evidence that discussions had taken place with other patients about these. 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 further 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.

The Commission has developed guidance in relation to advanced statements, which can be found at: https://www.mwcscot.org.uk/law-and-rights/advance-statements

Adults with Incapacity (Scotland) 2000 Act ('the AWI Act') section 47 consent to treatment certificates were in order along with accompanying care plans. 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.

In the case files we reviewed, where there was a welfare proxy (guardian or power of attorney) in place, details of this had not been recorded fully. Staff we spoke to were unsure of what powers were in place and were not aware that powers could be delegated to them as care providers.

The Commission has developed a good practice guide 'Working with the Adults with Incapacity Act – for people working in adult care settings' to support clarity in roles and responsibilities regarding the use of welfare powers in care settings. This can be found here: https://www.mwcscot.org.uk/sites/default/files/2020-08/WorkingWithAWI_June2020.pdf

We suggest the use of the Commission's checklist for ease of ensuring guardianship details are contained in individual files and details of delegated powers are clearly identified. The checklist can be found in this good practice guide.

Recommendation 1:

Managers should ensure that training and education is available to staff to promote and enhance their knowledge and understanding of the Adults with Incapacity (Scotland) 2000 Act

Recommendation 2:

Managers should ensure there is a clear process to identify when there is a welfare proxy in place and ensure this is documented clearly and accurately. Managers should also ensure that evidence of discussion with the proxy about how any powers are delegated to staff is clearly recorded.

Rights and restrictions

Ward 2 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 their Mental Health Officer (MHO). 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 2 has a dedicated activity co-ordinator who works Monday to Friday 9am-5pm. Unfortunately, they had been absent for a number of months prior to our visit and as a result, we heard there had been minimal activity on the ward. Patients reported feelings of boredom and lack of stimulation and exercise. Since the coordinator's return to work, an activities programme has been implemented and both patients and relatives commented on the difference activity and occupation made to individuals in the ward.

There is an occupational therapist (OT) who covers several of the mental health wards and who provides assessment on focused activities.

At our last visit, we recommended that managers should ensure that there are adequate numbers of suitably qualified staff available to allow patients flexible access to the gym. We heard that OT staff were now trained to take patients to the gym; however, in the absence of the activity co-ordinator and Covid-19 restrictions limiting the number of patients who can use this facility at any one time, access was very limited. Some patients were unaware that there was a gym they could use.

Recommendation 3:

Managers should ensure there is a structured, scheduled, meaningful activity programme available to patients seven days per week and provisions are put in place to support meaningful activity in the absence of the activity co-ordinator. Managers should also ensure access to the gym is supported and maintained.

The physical environment

The layout of the ward consists of 20 single rooms, nine of which have en-suite facilities. There is a lounge area and a separate quiet area. 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. A number of patients

we spoke to, described the ward as noisy at times and the television in the main sitting room was not working. We were informed a replacement is on order.

There is a private courtyard for the use of the patients in Ward 2 and we could see efforts had been made to ensure this is well maintained.

There is a kitchen available for patients to use with the support of occupational therapy staff. The washing machine within the laundry room was not working at the time of our visit and we were advised patients could use the facilities in the neighbouring ward.

Summary of recommendations

1. Managers should ensure that training and education is available to staff to promote and enhance their knowledge and understanding of the Adults with Incapacity (Scotland) 2000 Act.

2. Managers should ensure there is a clear process to identify when there is a welfare proxy in place and ensure this is documented clearly and accurately. Managers should also ensure that evidence of discussion with the proxy about how any powers are delegated to staff is clearly recorded.

3. Managers should ensure there is a structured, scheduled, meaningful activity programme available to patients seven days per week and provisions are put in place to support meaningful activity in the absence of the activity co-ordinator. Managers should also ensure access to the gym is supported and maintained.

Good practice

We saw and heard first-hand the positive influence the introduction of Improving Observation in Practice (IOP) safety checks were having. The ward has a clear visual system in place for staff to record their interactions with every patient every hour. A traffic light system is used to identify each individual's presentation which highlights if further interaction or input is required. This information is readily available for all staff and is recorded in individual care records. The activity co-ordinator has begun to use this to identify opportunities for meaningful activity and occupation to reduce stress and distress. Patients commented on the benefit of this approach and said it offers them opportunities to speak with staff regularly about how they are feeling without having to seek staff out.

The ward has also introduced a values management approach which includes the introduction of staff and patient experience questionnaires. Examples of improvement work includes 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 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 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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