Mental Welfare Commission for Scotland

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

Date of visit: 19 May 2022

Where we visited

At the Commission, due to the Covid-19 pandemic, we have had to adapt our 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 able to be carried out face to face.

Ward 4 is a 16-bedded unit which provides assessment and treatment for older adults with dementia. The ward admits both male and female patients. On the day of our visit there were four vacant beds.

Prior to the Covid-19 pandemic the ward had capacity for 20 beds, however since 2020 the service has created a four-bedded Covid-19 screening area which is shared with Ward 5. This area is used for all new older adult admissions.

The ward has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, physiotherapy staff and a pharmacist. There is also input as required from psychology and referrals can be made to all other services as and when required.

We last visited this service on 3 December 2019 and made recommendations regarding patients' access to independent advocacy and access to outside space.

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

Who we met with

We met with and/or reviewed the care and treatment of five patients and spoke with three relatives.

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

Commission visitors

Gillian Gibson, nursing officer

Juliet Brock, medical officer

Kathleen Taylor, engagement and participation officer (carers)

What people told us and what we found

Care, treatment, support and participation

Due to the progression of their illness, we were unable to have detailed conversations with patients, however, throughout the day we introduced ourselves to a number of patients and observed them to be content and relaxed in the ward. We observed supportive and positive interactions between ward staff and patients during our visit; it was evident from these observations and discussions with staff that they were knowledgeable and enthusiastic regarding their patients and the care and input that they provide.

Feedback from most relatives was generally very positive. They described the staff as excellent, they told us that they felt involved and informed in care decisions. To ensure consistency in this approach for all relatives, we would suggest that the service considers a means of providing regular feedback and open lines of communication with relatives and carers and clarify this formally on admission.

Visiting arrangements continue to be supported and although there is no designated visiting area, we observed visits taking place in different areas of the ward. At the time of our visit, arrangements were made via a booking system but we were pleased to hear that the ward has adopted a person centred, flexible approach to visiting where this has been required, particularly if someone was receiving end of life care.

Nursing care plans

We found good examples of person-centred care planning covering a range of care for mental health and physical wellbeing, however, we felt that care planning for stress and distress could be more detailed in relation to specific stress and distress interventions. We heard that the ward was taking part in the 'Health Improvement Scotland Dementia Collaborative' and had implemented stress and distress symptom scale bundles which once completed, informed care planning. However, these care plans were in paper format and as such were stored separately. We felt that all care plans should be in one place or the information collated and detailed in these should be accurately reflected in the electronic care plans. We would also expect to see more evidence of relative and/or carer involvement in care planning, particularly where there is a welfare proxy in place.

We saw that physical health care needs were being addressed and followed up appropriately.

When we reviewed the care plans we were unable to locate robust summative reviews which targeted nursing intervention and individuals' progress. We discussed this with the senior charge nurse on the day of our visit. There was a clear awareness of reviews happening but rather than a detailed summary, care plans were rewritten to reflect changes. Although this practice ensures that care plans in place are current and meaningful, it was difficult to see what progress had been made to meet specific goals and interventions

Recommendation 1:

Managers should ensure that care plan reviews and evaluations are clearly recorded in the nursing notes with details of progress in relation to goals and interventions.

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/node/1203

Multidisciplinary team (MDT)

The ward has a broad range of disciplines either based there or accessible to them. MDT meetings take place weekly and are currently attended by nursing, medical, occupational therapy (OT) and pharmacy staff.

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 (Mental Health Act) status and Adults with Incapacity (Scotland) 2000 Act (the AWI Act). This acts as a prompt for review, provides a detailed record and a good overview of care and treatment

Although patients and relatives are not invited to attend MDT meetings, we saw evidence that patients are regularly seen and reviewed by the team following meetings and separate meetings were held with relatives and/or carers to discuss progress on the ward.

We found comprehensive detailed reviews by the OT and medical staff along with pharmaceutical care assessments.

There is a physiotherapy gym attached to the ward and were pleased to hear that a physiotherapist has been recently appointed. Meantime, the physiotherapy assistant provides one-to-one interventions with patients on a referral basis in relation to strength, balance and mobility.

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, nine patients were subject to detention under the Mental Health Act (Care and Treatment) (Scotland) Act 2003 (‘the Mental Health Act’). The relatives we spoke to during our visit had a good understanding of the detained status.

Of those patients subject to compulsory treatment, we reviewed the legal documentation available in their files. Paperwork relating to treatment under part 16 (ss.235-248) 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 and up-to-date.

Adults with Incapacity (Scotland) Act 200 ('the AWI Act') section 47 consent to treatment certificates were in order along with accompanying care and treatment plans, most of which had been discussed and agreed with relatives/carers. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate must be completed under section 47 of the AWI Act by a doctor. The certificate is required by law and provides evidence that the treatment complies with the principles of the Act.

Where there was a welfare proxy (guardian or power of attorney) in place, details were recorded and copies of powers were kept in individual files.

For those patients on covert medication pathways, all documentation was in place and reviewed regularly.

Rights and restrictions

Ward 4 continues to operate a locked door policy, commensurate with the level of risk identified in the patient group. This was clearly displayed in the ward on the day of our visit. We also saw evidence of individual risk assessments that identified patients who would be at risk if the door were to be open, due to their vulnerability and progression of their illness.

On our last visit, we made a recommendation in relation to patients' access to independent advocacy services. We were pleased to find evidence of advocacy involvement, particularly for patients subject to detention under the Mental Health Act.

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 4 has an activity co-ordinator who works between Ward 4 and Ward 5. The ward also has a dedicated OT and OT assistant. There is an activity room in the ward which is open at all times. Activities are facilitated in both group and on a one-to-one basis. We heard that rather than have an activity programme in place, activities are planned on the day to take into account each individuals presentation. We saw detailed evidence in the care records that activities are regularly being offered and taking place. We saw that patients' likes and dislikes were explored with them and their relatives and/or carers to ensure activities offered were meaningful to each individual. We also saw a range of activities being offered on the day of our visit.

There was a kindle and laptop on the ward which was used to provide visual stimulation for patients on a one-one basis.

Now that Covid-19 restrictions are beginning to lift and patients are once again able to resume community activities, we saw evidence that these were being explored and facilitated. We also heard that there are plans to recommence pet therapy in the coming weeks.

The physical environment

The layout of the ward consists of sixteen single rooms each with en-suite facilities. Each bedroom had a whiteboard that staff had used to promote orientation and detail person centred information including life stories, likes, dislikes and 'what matters to me'.

The ward was bright, spacious and immaculate and we were able to see efforts made to promote a homely and inviting environment. There were tasteful murals on the walls along with sensory stimulating wall mounts to occupy patients around the ward. Seating areas had been made in the corridors and there is a lounge area and a separate dining area for the patients. The sitting room is quite small but we were told of the proposal that has been submitted by the MDT to extend the ward to better utilise space available. We were impressed by the proactive and creative thinking that had been put into this proposal with the patient needs at the centre of this.

On our previous visit we had made a recommendation in regard to patients' access to outside space. We were pleased to see that a garden courtyard had been created. This was accessible from several parts of the ward and contained good seating and use of space. Planters had been purchased and used for gardening groups and we were able to see patients enjoying the garden on the day of our visit.

Any other comments

We spoke with the OT during our visit and heard about the quality improvement pilot project that was underway to support meaningful activity on discharge from the ward. We heard about the challenges that are often faced in providing meaningful occupation for people with moderate to advanced dementia. Collaboration had begun with OT colleagues in one of the community hospitals and they were in the process of creating person centred activity plans that would follow patients on their journey to community hospitals and nursing homes. This work will also support the formulation approach of person centred interventions to support stress and distress and will provide continuity of care to support a successful discharge from the ward.

Summary of recommendations

1. Managers should ensure that care plan reviews and evaluations are clearly recorded in the nursing notes with details of progress in relation to goals and interventions.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the date 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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