Mental Welfare Commission for Scotland

Report on announced visit to: Forth Valley Royal Hospital, Ward 5, Stirling Road, Larbert FK5 4WR

Date of visit: 26 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 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 5 is an acute mental health admission ward for older adults with a functional illness or with an early diagnosis of dementia. It has 20 single rooms with en-suite facilities and is based in Forth Valley Royal Hospital. The ward also shares a four-bedded Covid-19 screening area with Ward 4 and is used for all older adult admissions.

The ward has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff (OT), an activity co-ordinator, psychology staff, a physiotherapy assistant and pharmacy staff. Referrals can be made to all other services as and when required.

We last visited this service on 29 November 2018 and made no recommendations.

Who we met with

We reviewed the care and treatment of seven patients, met with four, and spoke with two 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

What people told us and what we found

Care, treatment, support and participation

We received positive feedback from patients and relatives about all staff in the ward. We heard that they are conscientious, helpful and on hand. Care and treatment options are explained and patients are given choice. Relatives told us that they are kept informed and support needs are discussed and put in place.

We did hear that staff are always busy and, at times, the ward appears short-staffed. We learned that the Covid-19 screening bay is staffed by Ward 5, which has an impact on staffing in the ward. There is also a member of staff required to sit at the ward door for safety and security purposes. This further reduces the number of staff available for care and treatment.

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 detailed evidence in care records to support that these were taking place regularly.

Visiting arrangements continue to be supported. We were disappointed to learn that there was no designated visiting area and that visits take place in individual's bedroom. We heard that patients mostly preferred to go out with visitors, rather than sit in their rooms. We were informed that this is currently being reviewed.

Nursing care plans

We found good examples of person-centred care planning, covering a range of care for mental health and physical wellbeing, however, the standard was variable. We found inconsistency in the level of detail in relation to interventions to meet goals and outcomes. There is an audit tool currently in place and senior staff review five case notes per week; we would have hoped to find a more consistent standard of care planning in the ward.

Patients we spoke to were unaware of what a care plan was and there was no documented evidence to suggest these were being discussed and reviewed. If someone was unable to agree to their plan of care, we would have expected to find a documented reason to support this.

There was clear evidence from both speaking to patients and reviewing the notes that discharge planning was underway however, there was a distinct lack of discharge care planning which we would expect to find in an assessment ward. We were informed that there were plans to introduce a 'dynamic discharge' approach in the ward and look forward to seeing the impact this has when we next visit.

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

Recommendation 1:

Managers should continue to support staff to develop person-centred care planning to include a more detailed description of interventions to meet goals and outcomes. Managers should also ensure all patients are supported to be fully involved in creating person centred discharge care plans and participate in regular reviews. Evidence of patient involvement should be clearly documented in their notes, including a detailed account of any reason why a patient disagrees with the care plan, or chooses not to be involved.

Multidisciplinary team (MDT)

We found good evidence of MDT involvement in care and treatment, including OT and pharmacy. There were detailed and thorough medical assessments available in the care notes. There was some variability in the MDT reviews in terms of details and outcomes; we would like to see more patient and relative/carer involvement and attendance at meetings. We heard that patients were not given the opportunity to attend meetings, however most medical staff see patients regularly and consistently, to provide feedback following these.

We were pleased to find a physiotherapy gym in the ward and heard how the physiotherapy assistant carries out one-to-one interventions with patients in relation to strength, balance and mobility. This is a referral-only service and unfortunately there is currently a physiotherapy vacancy which the service is trying to recruit to.

We heard positive feedback from both patients and relatives regarding the OT assistant and the standard of support and input they provide.

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 act documentation. 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 seven patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('Mental Health Act'). The patients we spoke to during our visit had a good understanding of their detained status and had been 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 reviewed patient files, we looked for copies of advanced statements. The term 'advanced statement' refers to written statements made under s274 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. We did not find any patients with an advanced statement on the day of our visit. 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.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the Adults with Incapacity (Scotland) Act, 2000 (AWI) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. Where a s47 consent to treatment certificates was required, we found these to be in order, along with accompanying care and treatment plans.

We did find that the treatment plans were generic and not particularly person-centred or detailed in relation to individual needs.

Where there was a welfare proxy (guardian or power of attorney) in place, details of this were not fully recorded. Staff we spoke to were unsure of what powers were in place and there was some confusion as to where this information was held. Staff were also unaware 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 2:
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) Act 2000.

Recommendation 3:
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 decision maker, about how any powers are delegated to staff, is clearly recorded.

Rights and restrictions

Ward 5 operates an open door policy; however, entry and exit to the ward is monitored by a staff member seated at the door. The purpose of this is to note who is coming and going from the ward, their expected time of return and what they are wearing at the time of leaving the ward.

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) and/or nursing staff. There is also a patient information leaflet available that highlights the work that advocacy services provide. We were pleased to hear that advocacy services had resumed face-to-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 5 has an activity co-ordinator who works between Ward 5 and Ward 4. There is also an OT assistant who facilitates groups and one-to-one activities. There was an activity planner available detailing the programme of activities; we found documented evidence that these were being offered and delivered on a daily basis. We were able to see activities taking place on the day of our visit and patients spoke positively about the wide range of activities on offer and how they enjoyed the social aspect of these, as well as the therapeutic benefit.

We saw that decider skills were being offered by the activity coordinator who is trained in this approach. Decider skills use cognitive behavioural therapy to support people in recognising their own thoughts, feelings and behaviours. This allows individuals to monitor and manage their emotions and mental health, increase their confidence and build resilience. We learned that one member of the nursing team was due to undertake decider skills training and we hope to see this being extended to the wider MDT. This would increase staff knowledge and skills in this approach and support patients to put into practice their learning from this approach.

The physical environment

The layout of the ward consists of 20 single rooms, all of which have en-suite facilities. There is a lounge area and a separate quiet area although this is currently being used as a staff area. The dining room had been closed for a period of time as a measure to prevent the spread of Covid-19. We were pleased to hear that this had recently re-opened and patients commented on how they prefer having meals in the dining room with fellow patients, as opposed to in their bedroom.

The ward is bright, spacious, clean and tidy. The lounge requires to be softened and consideration given to have furniture that would make this area more inviting and comfortable.

There were signs on each bedroom door with the patient's name and details of their named nurse and consultant. There was signage around the ward to identify specific rooms and areas, however, these did not stand out. Several of them had spelling errors and they were not at the optimal height to support orientation. We were informed arrangements have been made to upgrade all signage in the ward and we look forward to seeing this on the next visit. Patients have access to an outside space in the form of a private courtyard, which can be accessed from several points in the ward.

Summary of recommendations

1. Managers should continue to support staff to develop person-centred care planning to include a more detailed description of interventions to meet goals and outcomes. Managers should also ensure all patients are supported to be fully involved in creating person centred discharge care plans and participate in regular reviews. 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.

2. 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.

3. 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 decision maker, about how any powers are delegated to staff, is clearly recorded.

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.

Claire Lamza
Executive director (nursing)

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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