Mental Welfare Commission for Scotland

Report on announced visit to:

Hope House, Bellsdyke Hospital, Bellsdyke Road, Larbert FK5 4SF

Date of visit: 24 August 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.

Hope House is a six-bedded, low-secure female unit in the community of Bellsdyke Hospital. The unit provides treatment, support and rehabilitation for women with more complex mental health care needs, who require greater levels of support and supervision. This facility opened in August 2017. The unit also has access to flats on the Bellsdyke site for the purpose of rehabilitation, to support discharge to the community. One the day of our visit there was one vacant bed.

The unit has a multidisciplinary team (MDT) consisting of nursing staff, psychiatry, occupational therapy staff, speech and language therapy staff, dietetic staff and psychology staff. Referrals can be made to all other services as and when required.

We last visited this service on 2 February 2020 and made no recommendations.

Who we met with

We met with, and reviewed the care of five patients, four who we met with in person and one who we reviewed the care notes of. We also met with one relative.

We spoke with the service manager, the senior charge nurse, the clinical nurse manager and the consultant psychiatrist.

Commission visitors

Gillian Gibson, nursing officer

Clare Lamza, executive director (nursing)

What people told us and what we found

Care, treatment, support and participation

We heard positive aspects about staff with some staff described as 'straight talkers' and 'non-invasive' who are 'willing to listen' and will go out of their way to spend time with patients when they recognise they are struggling and need more support. The occupational therapist (OT) and activity coordinators were described as "lovely" with patients viewing them as a "great addition" to the team. We were told that their input is helpful in relation to supporting and preparing for discharge. We also heard that relative's relationships with the senior charge nurse (SCN) and consultant psychiatrist was very good, with open lines of communication and the ability to have open conversations and discussions.

However, there appears to be an inconsistent approach in the nursing staff team with some nursing staff being described as "nasty" and "disinterested" who have their own opinion of patients, which we heard can appear judgemental. We were told that at times, some staff are heard to openly discuss what patients consider confidential information in the main body of the ward. We also heard that some staff have been overheard discussing personal issues, which patients were unhappy about.

We are aware that the ward was initially set up based on a trauma-informed model and due to recent changes in the patient and staff group, the focus on staff training has changed. We heard that the Covid-19 pandemic has also had an impact on the availability and accessibility of specific training required to work with this complex patient group. We heard that the service is currently reviewing the induction programme for new staff to make this more robust with a focus on education and training requirements, however, we feel a more targeted approach is required to address the current contrast in staff culture in the ward.

Recommendation 1:
Managers should ensure that there is appropriate training and supervision for all staff in the ward with a specific focus on mentoring and coaching to address the current contrast in culture.

Care planning

When we last visited the service we found examples of detailed and person-centred care plans which addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. We were pleased to see that on this visit, these continued to be of the same standard, and again we found detailed person-centred care plans that evidenced patient involvement. We also found comprehensive information contained in patient's one to one discussions with their named nurse. We were able to locate robust care plan reviews which targeted nursing intervention and individuals' progress.

Patient engagement

We heard that daily planning meetings are held each morning that give patients the opportunity to plan their day, with a focus on one-to-one interventions, appointments and OT activities. A weekly community meeting is also held with staff and patients; this was recently reviewed to include a patient-led standing agenda, and supports patients to raise any concerns they may have. There is a suggestion box in the ward and we heard that a patient and carer

questionnaire is due to be rolled out to enable meaningful feedback to be collated. We look forward to hearing more about this on our next visit.

Multidisciplinary team (MDT)

The unit has a broad range of disciplines either based there or who are accessible to patients. MDT meetings take place fortnightly and 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 provide an update on their views. Patients are asked in advance what they would like raised at MDT meetings and are supported to attend regularly. There is also an open invitation for relatives and carers to attend if they wish. A 'Situation, Background, Assessment and Recommendation' (SBAR) template is used for both patients and staff to raise any specific issues.

The unit has recently introduced progression plans which we considered provided a good visual template, clearly identifying individual goals for each patient. These were person-centred and we were pleased to see the attention to detail given to these plans.

Care Programme Approach (CPA) meetings are held on a six-monthly basis for every patient and these were clearly recorded with timely outputs covering all key areas. We were pleased to see evidence of patient and relative involvement and a strong focus on rehabilitation and positive risk-taking.

There were some concerns raised regarding psychology input and we heard that some patients had identified specific issues they felt they needed support with but were told this was not required for them. We heard that patients feel psychology input has reduced of late and we were unable to find detailed psychology assessments in the care records. We would suggest that the role of psychology and current process for documentation of assessment is reviewed to be of more benefit to the model of the unit.

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, all five of the patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, (MHA). The patients we met with during our visit had a good understanding of their detained status and all documentation pertaining to the MHA was accessible and in order. Part 16 of the MHA sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) were in place where required, and corresponded to the medication being prescribed. These had all been updated prior to our visit.

We found that there was no T3 to record non-consent for one patient but a second opinion from a designated medical practitioner had been requested.

Any patient who receives treatment under the MHA can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found details of this in the patient's file.

Rights and restrictions

Hope House continues to operate a locked door, commensurate with the level of risk identified with this patient group.

We found thorough, detailed risk assessments in place for each patient that also identified strengths and protective factors. These were person-centred, included the views of patients and carers, and were reviewed and updated regularly.

Where patients were subject to continuous interventions we saw evidence that this was reviewed regularly and were pleased to see detailed recovery plans in place. We were able to locate improving observation in practice contact records in individual files but these did not particularly reflect the level of detail we would expect to see. This was raised with managers on the day of our visit.

S281 to 286 of the MHA 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 these sections of the MHA, and where restrictions are introduced, it is important that the principle of least restriction is applied.

On the day of our visit, there were no specified person restrictions in place under the MHA. However, we heard that mobile phone use was restricted in the ward in order to promote structure and engagement throughout the day. We also heard that patients are sometimes searched on their return to the ward to ensure safety and security. We discussed this with managers on the day and suggested that this is captured in ward policy, discussed regularly with patients and consent is obtained and clearly recorded. There also needs to be consideration given to what happens should a patient refuse to be searched or requests more frequent mobile phone use.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files we look for copies of advanced statements. The term 'advance statement' refers to written statements made under ss274 and 276 of the MHA, and is written when a person has capacity to make decisions on the treatments they want or do not want should they become unwell again in the future. Health boards have a responsibility for promoting advance statements. On the day of our visit we were able to locate advance statements where these were in place, but we would have expected these to be reviewed with patients regularly to ensure they continue to reflect their views. We saw evidence in the care records and care plans that some discussions were taking place in relation to advance statements but not all patients were aware of what these were, or their right to make one. The Commission supports the use of advance 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 that are made to engage patients in a discussion regarding advanced statements, and the reason noted for any patient that does not have one.

There was some confusion from the patient group as to whether advocacy services had resumed face-to-face visits and we heard of the difficulties patients encounter with telephone support. We were pleased to hear from ward managers that advocacy services have resumed face-to-face visiting and we asked that this information be relayed to patients in the ward.

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

The ward has two activity coordinators and an OT who provide structured activities for patients. We saw evidence of activities taking place on the day of our visit and heard how patients are supported to identify, agree and plan activities for the following week. Details of activities were visibly displayed on the ward activity planner. Patients are encouraged to carry out their own everyday living activities as much as possible. This is based on the 'home-style' model of care that encourages patients to further develop their skills for moving towards community living. Patients work together with ward based MDT staff, to create an environment that responds to patient's evolving needs. This includes menu planning, shopping, cooking and carrying out all daily domestic chores in the ward environment. Each patient has an individual seven-day activity programme that is reviewed regularly and detailed in their person-centred care plans. We were pleased to see the move to community activities for individuals and to hear about the positive impact this is having on the patient group. We found it difficult to find details of activities offered and undertaken in individual care records and would want to have this documented more clearly.

There is an activity room in the ward however, this is currently used to store activity equipment. We felt that the ward would benefit from having a designated activity room that was fit for purpose, and therapeutic engagement.

The physical environment

The layout of the ward consists of six single rooms. There is a lounge area and a separate dining area for the patients, both are large and spacious. The environment was sparse and in need of remedial work to update and refresh it and efforts require to be made to soften the public rooms, including the quiet room.

We heard that the ward is often noisy, particularly at night and there is very little storage available.

Patients told us that not having en-suite facilities was "awful" and we heard that patients have to keep toilet roll in their room at times for use in the shared toilets. We heard of issues with the bathroom and shower room, in regards to water temperature and actually getting water from the shower, which can be sporadic.

The unit has access to a garden area that requires some attention to make it more pleasant for use. The fence placing requires to be reviewed as a room from the neighbouring ward currently overlooks the garden area. This was pointed out by a patient on the day of our visit.

We were pleased to see that a sensory room had been created in the ward but this was very small, and requires investment to be more conducive to a therapeutic space.

Recommendation 2:
Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as practicable and efforts made to soften public rooms.

Recommendation 3:
Managers should ensure there is a system is in place to ensure maintenance requests are responded to in a reasonable timeframe.

Recommendation 4:
Managers should ensure that a programme of works is developed, with identified timescales, to address the environmental issues including the need for en-suite bathrooms, storage availability and the size of therapeutic rooms.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is appropriate training and supervision for all staff in the ward with a specific focus on mentoring and coaching to address the current contrast in culture.

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Good practice

We heard that the ward team has started to implement a values management approach which includes plans to introduce patient led projects of improvement. The staff continue to adapt well to the changing needs of the patient group. We were pleased to see that the unit has been successful in moving individuals on to more appropriate environments to meet their needs. We heard that patients generally feel safe and supported in the ward.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk