Mental Welfare Commission for Scotland

Report on announced visit to: Tryst Park, Bellsdyke Hospital, Bellsdyke Road, Larbert FK5 4SF

Date of visit: 13 September 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.

Tryst Park is a 12-bedded, low secure male ward in the community of Bellsdyke Hospital. The unit provides treatment, support and rehabilitation for men with more complex mental health care needs, who require greater levels of support and supervision. Bed numbers were reduced in February 2022 from 18 beds, following a review of national low secure unit provision. The ward also has access to three on-site supported living flats and four off-site flats. These flats are shared with the other Bellsdyke wards and are identified as a good resource to support discharge to the community. On the day of our visit there were two vacant beds

We last visited this service on 27 February 2020 and made recommendations in relation to OT access, restrictive practices, person-centred approaches to management of illicit drug use and the cleanliness of outside spaces. On the day of this visit we wanted to follow up on these recommendations and hear how patients and staff have managed throughout the current Covid-19 pandemic.

Who we met with

We met with, and reviewed the care of five patients. We also met with advocacy services.

We spoke with the service manager, the senior charge nurse (SCN), the charge nurse and the clinical nurse manager.

Commission visitors

Gillian Gibson, nursing officer

Lesley Paterson, senior manager, east team (practitioners)

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

Care, treatment, support and participation

Feedback from patients was generally good with positive comments in relation to staff. We heard they were “nice” and know the patients well. Patients feel they can talk to staff, are listened to and any concerns they have are taken on board. They feel involved in care decisions and that nursing staff keep them safe and look after them.

However, we heard that escorted time out of the hospital grounds could not always be facilitated due to staff shortages. Some patients also felt frustrated being in the ward for an extensive period of time, and were keen to be discharged.

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 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 sustains the quality of care provided.

Care planning

When we last visited the service we found some care plans were lacking in detail and required evidence of patient participation. A number of care plans were written in a way that would not be considered encouraging or positive, therefore may have had an impact on collaborative working between staff and patients.

On this visit, we were pleased to find examples of detailed and person-centred care plans which were written in positive language that would support and promote therapeutic engagement with patients. Care plans addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual; we found consistent evidence of patient involvement. We did however feedback to managers that we would hope to see patient views of their care plans captured using their own words.

On our last visit we made a recommendation that that illicit drug use, or suspected illicit drug use, is considered in an individualised way and is part of a person-centred care plan. We were pleased to find specific detailed person-centred care plans addressing illicit drug use in place on the day of our visit.

When we reviewed the care plans we were unable to locate robust summative reviews which targeted nursing interventions and individual’s progress, and discussed this with the senior charge nurse on the day of the 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 the care plans that are in place are current and meaningful, it was difficult to see what progress had been made to meet specific goals, and which interventions have been effective.

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 the effectiveness of interventions evaluated.

Patient engagement

We heard that a weekly community meeting is held with staff and patients, providing an opportunity for staff to update patients on information and activities, and for patients to raise any concerns they may have. Minutes are kept to highlight points raised and solutions found; these are displayed on the ward notice board. One-to-one sessions with nursing staff and key workers were planned and noted in individual activity planners each week and we found detailed accounts of these in the patient notes.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) consisting of nursing staff, psychiatry, occupational therapy (OT) staff, pharmacy and psychology staff who are either based there, or who are accessible to patients. Referrals can be made to all other services, such as speech and language therapy, dietetics and physiotherapy as and when required.

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. We heard that advocacy staff attend MDT meetings if patients request this support. There is also an open invitation for relatives and carers to attend if they wish, but we found limited evidence of relative/carer involvement. A Situation, Background, Assessment and Recommendation (SBAR) template is used for both patients and staff to raise any specific issues.

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 involvement and a strong focus on rehabilitation and positive risk-taking. We were also pleased to see a MDT collaborative approach to discharge planning.

Physical healthcare of the patient group is supported by the local GP practice. We heard that prior to the Covid-19 pandemic the patients received a good service; however, face-to-face contact is now very limited with the majority of consultations offered via telephone.

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.

We were pleased to find a high standard of record keeping with regular detailed entries of observations and interactions in the continuous care records.

Improving Observation in Practice (IOP) safety checks are undertaken regularly. A traffic light system is used to identify each individual's presentation, which highlights if further interaction or input is required. This information is recorded in individual care records.

Use of mental health and incapacity legislation

On the day of our visit, all patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, (the Mental Health Act). The patients we met with during

our visit had a good understanding of their detained status and all documentation pertaining to the Mental Health Act was accessible and in order. Part 16 sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were available and in order. Consent to treatment certificates (T2) were in place where required, and corresponded to the medication being prescribed. There was one patient who did not have a signed consent form available and we discussed this with managers on the day. We also highlighted the importance of specifying the route of medication administration that the patient is consenting to.

Any patient who receives treatment under the Mental Health Act 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.

In the case files we reviewed, where there was a welfare proxy (guardian or power of attorney) in place under the Adults with Incapacity (Scotland) 2000 Act (AWI), details of this had been recorded, however there was not a copy of the order available in the ward. Staff we spoke to were unsure of what powers were in place. We discussed the importance of knowing what powers had been granted to the welfare proxy and what powers had been delegated to them as care providers.

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 that where there is a welfare proxy in place, a copy of the order is obtained for ward records and evidence of discussion with the proxy about how any powers are delegated to staff is clearly recorded.

Rights and restrictions

Tryst Park continues to operate a locked door policy, commensurate with the level of risk identified with this patient group.

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

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 legislation, and where restrictions are introduced, it is important that the principle of least restriction is applied. When we last visited, we recommended that any restrictions in place are the least restrictive necessary, in order to keep the patients and others safe.

On the day of our visit, there were specified person restrictions in place for nine patients. The appropriate documentation was not available in every patient's file to authorise all restrictions.

We were also concerned about some of the reasoned opinions provided, which for some patients appeared to be a 'blanket approach' to ward procedures and not based on individual risk assessment.

We discussed this with managers and suggested that ward policy is reviewed to capture the use of mobile phones, and of search procedures, which should be discussed regularly with patients and consent obtained and clearly recorded. Where patients consent is formally noted for specific interventions, specified person restrictions would not be required.

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

Recommendation 4:
Managers should ensure that any decisions to subject a patient to specified person legislation, are necessary, person-centred and the appropriate documentation is completed and available in patient files.

When we are reviewing patient files we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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 should they become unwell again in the future. Health boards have a responsibility for promoting advance statements. On the day of our visit 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.

We were pleased to hear that advocacy services had resumed face-to-face visits and we saw evidence of support provided by advocacy services on the day of our visit. Advocacy staff told us that at present there is no designated worker specifically for Tryst Park. Currently referrals are allocated to whomever has availability at that time. We heard this may be reviewed as it was felt that an identified worker for the ward would support regular visits and a drop-in service to the ward, enhancing working relationships with staff and providing increased availability of advocacy presence for patients.

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

Activities are currently provided by nursing and OT staff. There is an activity programme in place which sets out the activities scheduled for the week, including pool tournaments, board games, walking groups and gym access. We were pleased to see a range of external agencies attending the ward to support activities, which included pet and art therapy. The ward has

developed good links with community services who are able to offer football groups, work experience and courses at the local college.

In addition to the ward planner, each patient is supported to identify, agree and plan activities for the following week. Information about these are recorded on an individual seven-day activity programme and kept in patient bedrooms.

Patients told us that activities available were good but they can still experience feelings of boredom. The ward does not have a dedicated activity co-ordinator and with the current staffing challenges, activities are not always able to be facilitated, particularly those in the community. We were told that an SBAR has been submitted with a proposal to convert Band 2 health care support worker vacancies to support recruitment of an activity coordinator; we look forward to hearing how this develops.

Patients have access to a laundry room on the ward with a timetable for individual use. We heard that this had been introduced at the request of the patients.

The physical environment

The layout of the ward consists of twelve single rooms divided between two areas in the ward. Each area has a lounge which is large and spacious and a quiet room. There is a separate dining area and activity room for all patients to use. Some of the bedrooms no longer in use have been developed into additional quiet spaces for use throughout the day.

We could see that efforts had been made to soften public rooms but these were still rather sparse and in need of remedial work to update and refresh them. We were pleased to hear that the community art group has been commissioned to develop pieces of art work to display in the ward and the art group were working on projects with the patients to enhance communal areas.

We heard that work was due to commence to upgrade certain aspects of the ward including the airlock entry, windows and anti-ligature work in line with the national low secure unit standards.

There are currently no en-suite facilities in the bedrooms and this was raised by patients on the day of our visit. The bathrooms and shower rooms require to be upgraded. We heard that plans have been drawn up to further reduce the beds numbers and add en-suite facilities to all rooms. This has been submitted for costing and we look forward to having updates regarding this.

When we last visited the ward we recommended managers ensure that the cigarette ends were cleaned up from the garden and ward entrance areas. We saw that the front of building had been resurfaced to support cleaning and heard that the garden is maintained on a monthly basis. We felt the garden area required upgrading to make it more pleasant for use. We heard that work is due to commence to replace the fence and landscape the garden area and look forward to seeing these improvements on our next visit.

Summary of recommendations

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 the effectiveness of interventions evaluated.

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 that where there is a welfare proxy in place, a copy of the order is obtained for ward records and evidence of discussion with the proxy about how any powers are delegated to staff is clearly recorded.

Recommendation 4:
Managers should ensure that any decisions to subject a patient to specified person legislation, are necessary, person-centred and the appropriate documentation is completed and available in patient files.

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.

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