Mental Welfare Commission for Scotland

Report on announced visit to:

Russell Park, Bellsdyke Hospital, Bellsdyke Road, Larbert FK5 4SF

Date of visit: 26 October 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.

Russell Park is an 11-bedded mental health rehabilitation ward with three on-site supported trial living bungalows; in addition there are four off-site independent trial living flats all of which can be accessed by the four wards of Bellsdyke Hospital. Russell Park is an open rehabilitation ward that builds and maintains strong links with community services. The aim of the ward is to support mental health patients to transition from in-patient care to a structured community based living that meets the individuals' requirements, following on-going assessments of independent living and social skills.

We last visited this service on 9 January 2020 and made one recommendation in relation to specified person procedures. On the day of this visit we wanted to follow up on this recommendation and hear how patients and staff have managed throughout the current Covid-19 pandemic.

Who we met with

We met with three patients, and reviewed the care of six patients. We also met with two relatives.

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

Commission visitors

Gillian Gibson, nursing officer

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

Feedback from patients was very positive with staff described as “kind”, “caring”, “warm”, and “approachable”. We heard both patients and relatives felt listened to and involved in all care decisions. Relatives told us they felt their family members were safe and secure in the ward with the care and treatment provided being “gold standard”.

We found detailed recorded one-to-one sessions with patients and saw comprehensive records of family contact and involvement. We heard there was a timetable in place to ensure every patient has at least one one-to-one session per week with a nurse and healthcare support worker.

Patient engagement

We heard that a weekly community meeting was held with staff and patients, chaired by the charge nurse. This provided an opportunity for patients to raise any concerns they may have and included identifying any activities they would like to see offered the following week. Minutes were kept to highlight points raised and resolutions found and were displayed on the ward notice board.

Multidisciplinary team (MDT)

The unit has an MDT consisting of nursing staff, psychiatry, occupational therapy (OT) and psychology staff. Referrals could be made to all other services, such as speech and language therapy and dietetics as and when required. Pharmacy input was also provided when required and support and advice could be obtained via telephone or email correspondence.

MDT meetings were well documented and it was clear to see who had attended. Each patient was invited to attend an MDT meeting once a month and we found good involvement of patients at these meetings. A Situation, Background, Assessment and Recommendation (SBAR) template was used for both patients and staff to raise any specific issues out with their identified meeting date.

We heard that psychology staff were unable to attend MDT meetings however, each week they meet with nursing and OT staff to discuss the patients due for MDT review. This ensured every patient is regularly discussed and reviewed prior to their MDT meeting.

Care Programme Approach (CPA) is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre. These meetings were held on a three-monthly basis and were clear records, with timely outputs, covering all key areas. We were pleased to see evidence of patient and relative involvement.

We heard from the psychologist about the work they were doing with staff and patients in Russell Park and across the wider Bellsdyke site. We heard that there were plans to create a psychology hub on site to up-skill nursing staff to deliver psychological therapies with supervision from the psychologists. We heard that they had recently introduced reflective practice with the nursing team in Russell Park, to enhance the care and treatment provided.

This had been positive with staff recognising and seeking support where required. They had also started to work with nursing staff to support a formulation approach for patients. Formulation is a structured approach to understanding factors underlying distressed states and behaviours. This process allows the MDT to make sense of patient's difficulties by learning about key experiences in their lives, and identifying individualised measures to support them. We look forward to seeing how this work progresses on our next visit.

We saw detailed involvement from the OTs and the stepped progression plans they had in place for each patient. This enabled staff and patients to identify achievable goals at a pace suitable to each individual.

We found limited evidence of social work or mental health officer input and heard from one patient they had not seen either professional for a considerable time. We fed this back to managers on the day of our visit.

Care records

Information on patient's care and treatment was 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 were able to input into this system, which promoted continuity of care, communication and information sharing. We found a good standard of record keeping, with regular detailed entries of observations and interactions, in the continuous care records.

Improving Observation in Practice (IOP) safety checks were undertaken regularly. A traffic light system was used to identify each individual's presentation that highlighted if further interaction or input was required. This information was recorded in individual care records.

Care planning

We found a range of care plans which addressed mental health and physical health needs, including detailed discharge planning that identified person-centred goals and interventions. Details of who was responsible for taking these forward were clearly identified. There was some variation in the language used in the care plans but these were generally written in positive, patient-friendly language. We heard that patients and relatives felt involved in care planning.

When we reviewed the care plans we were unable to locate robust summative reviews which targeted nursing intervention and highlighted individuals' progress. Care planning contact records were comprehensive and detailed but we would hope to see these used more to detail a summary of the care plans to document what progress had been made to meet specific goals and which interventions had been effective.

Recommendation 1:
Managers should ensure that patient care plans include summative evaluations that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

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 here:
https://www.mwcscot.org.uk/node/1203

Use of mental health and incapacity legislation

On the day of our visit, 10 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, (the Mental Health Act). Documentation relating 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 forms authorising treatment (T3) were available and in order. Consent to treatment certificates (T2) were in place where required, and corresponded to the medication being prescribed.

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. Relatives we spoke to were fully aware of their rights as a named person and felt informed and involved.

Rights and restrictions

Russell Park operates an open door policy. All of the patients we met with appeared fully aware of their rights.

We found detailed risk assessments in place for each patient and saw that these linked directly to care plans. These 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 these sections of the Act, and where restrictions are introduced, it is important that the principle of least restriction is applied.

When we last visited the service, we made a recommendation in relation to specified person procedures being in place to authorise restrictive practices. On the day of our visit, three patients had specified person restrictions in place. The appropriate documentation was available in every patient's file to authorise all restrictions, including evidence of a reasoned opinion for each patient.

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. 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. Health Boards have a responsibility for promoting advance statements. We saw posters and leaflets promoting advance statements on the ward and did see from the files that some patients had one, however, the patients we spoke with either did not know of their right to make one or had approached staff who told them to talk to their advocacy worker about this. We were told that the advocacy service was planning to promote advance statements and felt this was a really

positive initiative, however we believe all staff should be able to support people with advance statements.

Recommendation 2:
Managers should ensure that training and education is available for staff to promote and enhance their knowledge of advance statements to enable them to confidently support patients with these.

We were pleased to hear that advocacy services had resumed face-to-face visits. We heard that prior to the Covid-19 pandemic this service had an identified worker for Russell Park and a weekly drop in service was provided. Staff felt this was beneficial for patients on the ward as patients knew when advocacy would be attending. This also supported working relationships with staff. Unfortunately this has ceased and patients were now referred for advocacy support, when required.

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 were provided by nursing and OT staff. There was an activity programme in place which detailed activities scheduled for the week including bowling, swimming, bingo, pool, healthy eating, baking and talking groups. Each patient also had an individual activity planner agreed and signed by them. There was a full balanced range of therapeutic, recreational and lifestyle opportunities available for each patient. We heard positive feedback from patients about the activities on offer to them in the ward with "lots to do" and good learning opportunities.

Patients had access to a laundry room on the ward which they could access throughout the day. The ward also has two kitchens in the patient areas. Meals were not delivered to Russell Park, instead each patient was provided with a budget, supported to buy their food for the week and cook and prepare their own meals. We heard that at times, access to the kitchen could be difficult but that patients could also choose when to eat without the constraints of set meal times.

The physical environment

The layout of the ward consisted of eleven single rooms divided between two areas in the ward.

Each bedroom has en-suite shower facilities. There was no bath for patient use. The three onsite bungalows compromise of an open plan living room, kitchen and dining area with a separate bedroom and shower room.

We heard that patients were reluctant to go to the bungalows as they were described as "dingy". We saw one of the bungalows and although recognised this was a good sized space and a good resource, found the carpet to be worn, stained and needing replaced. The furniture was worn and the kitchen and shower room required to be upgraded.

We found the main ward to be tired in appearance and requiring upgrading. Efforts need to be made to soften public areas and furniture in bedrooms replaced. We heard that a plan was in place to work with a community art project group to enhance the ward environment and we look forward to seeing how this work progresses.

The ward had access to a large open garden and we heard that new garden furniture had been ordered. We also heard there were plans to introduce horticultural therapy to enhance the garden area and provide additional activities for patients.

There is a significant amount of work required to ensure ligature points are reduced in the ward and we feel this work requires to be prioritised.

Recommendation 3:
Managers should ensure a programme of work, with identified timescales, to address the environmental issues both in the main ward and in the onsite bungalows.

Recommendation 4:
Managers should ensure a programme of work, with identified timescales, to address the ligature risks.

Summary of recommendations

Recommendation 1:
Managers should ensure that patient care plans include summative evaluations that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 2:
Managers should ensure that training and education is available for staff to promote and enhance their knowledge of advance statements to enable them to confidently support patients with these.

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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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