Mental Welfare Commission for Scotland

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

Date of visit: 6 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.

Tryst View is a 20-bedded mixed-sex, slow-stream mental health rehabilitation ward in the community of Bellsdyke Hospital. 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 seven vacant beds in the ward.

We last visited this service on 26 February 2019 and made recommendations in relation to care planning and nursing documentation. 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 four patients, and reviewed the care of six patients. We also met with two relatives and spoke with one relative via telephone.

We spoke with the service manager, consultant psychiatrist, psychologist, senior charge nurse, charge nurse, healthcare support worker and the clinical nurse manager.

Commission visitors

Gillian Gibson, nursing officer

Lesley Paterson, senior manager, east team (practitioners)

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

Feedback from patients and relatives was generally good with staff described as “kind”, “caring”, and we heard they “do a good job”. However, we were told there were not enough of them. We also heard both patients and relatives feel they could be more involved in their care with more open lines of communication.

We found limited evidence of one-to-one sessions with patients taking place and heard from patients that if these sessions took place more frequently that this would be helpful.

Staffing challenges were acknowledged by managers who were 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 in order to enhance the quality of care provided.

During the Covid-19 pandemic, the acute mental health wards in Forth Valley Royal Hospital experienced a pressure on beds and in order to support this, Tryst View had been used to board patients from the acute wards. We were told about the challenges this had posed. On the day of our visit one patient was boarding in Tryst View. We were advised that a standard operating procedure is being developed by the senior charge nurse to address this.

Care planning

When we last visited the service we recommended a review of the audit process to improve the quality of care plans and ensure that care plans were person-centred, reflected the holistic care needs of each patient, and identified clear interventions and care goals.

We heard that an audit process had been implemented and on this visit, we found a range of care plans which addressed mental health and physical health needs however, these were not written in positive, patient-friendly language. We found them to be prescriptive and instructive with a focus on diagnosis, rather than the holistic needs of the patient. Care plans should be descriptive of the interventions required to provide individualised care, particularly in relation to mental health. We were also unable to find consistent evidence of patient involvement.

When we reviewed the care plans we were unable to locate robust summative reviews which targeted nursing intervention and highlighted individuals’ progress. There was an 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, it was difficult to see what progress had been made to meet specific goals and which interventions had been effective.

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 ensure all patients are supported to be fully involved in creating person-centred care plans and participate in regular reviews. Care plans should be written using patient friendly language, descriptive of the interventions required to provide individualised care.

Recommendation 2:
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 chaired by the senior charge nurse. This provides an opportunity for patients to raise any concerns they may have. Minutes are kept to highlight points raised and solutions found; these are then displayed on the ward notice board.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) of nursing staff, psychiatry, occupational therapy (OT) staff, physiotherapy and psychology staff. Referrals can be made to all other services, such as speech and language therapy and dietetics as and when required. There was no regular pharmacy input to the ward but support and advice can be obtained via email correspondence.

MDT meetings were well documented and it was clear who had attended. There were two consultant psychiatrists who cover the ward and we found different models in place regarding frequency of MDT meetings. We heard this was due to a recent change in consultant cover and there was a requirement to review some patients more frequently.

We found limited involvement of patients at MDT meetings but found documentation to support patients being seen by their consultant afterwards. We would expect to find evidence of a reasoned discussion recorded in the patient's notes, if the patient chooses not to attend, or the patient is unable to attend. We heard from relatives that they did not regularly attend MDT's and as a result did not feel involved in care decisions, or felt there was no formal arrangement in place to support involvement and communication.

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 six-monthly basis and were clearly recorded, with timely outputs covering all key areas. We were pleased to see evidence of patient and relative involvement although heard that due to the Covid-19 pandemic, many of these had been held virtually.

We heard from the psychologist that they had started working with nursing staff to support a formulation-style approach for each patient. Formulation is a structured approach to understanding factors underlying distressed states and behaviours. This process will allow 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.

Physical healthcare of the patient group is supported by the local GP practice and we were pleased to hear that this service has been unaffected by the Covid-19 pandemic.

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.

When we last visited we made a recommendation in relation to the standard of record keeping. On this visit we were pleased to find that generally, there was 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, which highlighted if further interaction or input was required. This information was recorded in individual care records.

Use of mental health and incapacity legislation

On the day of our visit, nine 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. However, relatives we spoke to were unaware of their rights as a named person and there appeared to be some uncertainty with staff as to what information could be shared. We raised this with managers on the day of our visit.

Where an individual lacks capacity in relation to decisions about medical treatment, a section 47 certificate of the Adults with Incapacity (Scotland) Act 2000 (AWIA) must be completed by a doctor. The certificate is required by law and provides evidence that the treatment complies with the principles of the AWIA. We were pleased to find s47 certificates in order, however we were unable to locate accompanying treatment plans and raised this with the senior charge nurse during the visit.

Rights and restrictions

Tryst View operates an open door policy, although, we were concerned to learn that the door is locked at specific times during the day. This happens mainly at mealtimes, medication

rounds and protected activity time. There did not appear to be a locked door policy in place to support this practice and we were concerned about the restrictions this placed on informal patients. Doors should be locked only after careful consideration of individuals' needs, and when alternatives have been fully explored. A policy on door locking needs to be discussed with those it affects at the point of admission; it should be available to staff and visitors. The policy should include information on how the person can come and go freely. Managers were aware of this practice and advised us this was due to be reviewed.

Recommendation 3:
Managers should ensure the current practice of locking the door throughout the day is reviewed as a priority and alternative measures to engage patients in ward routine and activities are explored and implemented.

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. We would hope to see the views of the patient and relatives included in the assessments, to identify strengths and protective factors.

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.

On the day of our visit, there appeared to uncertainty around how many patients had specified person restrictions in place. A review of care records identified specified person restrictions were in place for three patients. The appropriate documentation was not available in every patient's file to authorise all restrictions, nor was their evidence of a reasoned opinion for each patient who had been designated as a specified person under the MHA.

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

Recommendation 4:
Managers should ensure where restrictions are in place, the appropriate documentation is completed and available in patients' files. There should be a process in place to ensure all staff are aware of individual specified person restrictions.

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. We were pleased to find patients had advance statements in place and available in their care records and we found evidence of discussions taking place with patients who did not have 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 were pleased to hear that advocacy services had resumed face-to-face visits and heard that patients are referred for advocacy support.

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 board games, crafts and jewellery making. There was also a pool table, table tennis table and keyboard available for use throughout the day.

We saw decider skills on offer as a therapeutic intervention and heard that further training was being delivered to staff to support to deliver this approach. We heard about the benefits of mindfulness for this patient group and were pleased to hear that staff are being supported to learn to deliver mindfulness sessions in the ward. However, patients told us that although staff try their best, they feel that more activities could be offered. The ward does not have a dedicated activity co-ordinator and with the ongoing staffing challenges, activities were not always able to be supported. We also heard of a reluctance from some staff to facilitate activities, which we found concerning. We discussed this with hospital managers on the day of our visit and suggested a review of the current establishment and vacancies to support an activity co-ordinator position.

Patients have access to a laundry room on the ward which they can use throughout the day. The ward also had three kitchens in the patient areas, however, we were disappointed to find these had been decommissioned. Patients have to go to a neighbouring ward to participate in kitchen assessments. We heard that this was being reviewed and it was hoped one of the kitchens will be replaced. We look forward to seeing how this work progresses on our next visit.

The physical environment

The layout of the ward consists of twenty single rooms divided between four areas in the ward referred to as 'houses'. Each house had a lounge which was large, bright and spacious.

There were no en-suite facilities in the bedrooms. The shower rooms had been upgraded however we heard the plumbing system was old and as a result, there would often be problems with low water pressure.

We could see that efforts had been made to soften public rooms and bedrooms had been personalised. There was a garden room which was used for visiting and one-to-one meetings but as this was the only access point to the garden, visits and meetings can be interrupted. We heard there were no other rooms available on the ward to support meaningful engagement, therapies or one-to-one meetings. We are aware of the service plan to submit a proposal to reduce the number of beds in Tryst View, as it is recognised twenty slow stream rehabilitation beds are not required for the Forth Valley population. Reducing the number of beds will also

help enhance the estate by creating space for en-suite bedrooms. We discussed with managers on the day that there is the possibility to remove bedroom furniture from the empty bedrooms to create private spaces for one-to-one interventions, and opportunities for therapeutic input. We also discussed the significant amount of work required to ensure ligature points are reduced in the ward and feel this work requires to be prioritised, particularly if the ward is used to board patients from the acute mental health wards.

The ward had access to a large garden which, although requires some maintenance, appeared to be a well-used space with opportunities for gardening groups, physical activity and ample seating available.

Recommendation 5:
Managers should ensure a programme of work, with identified timescales, to address the ligature issues.

Summary of recommendations

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Recommendation 5:
Managers should ensure a programme of work, with identified timescales, to address the ligature issues.

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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