



Mental Welfare Commission for Scotland

Report on announced visit to:

Ward Two, Bo'ness Community Hospital, Dean Road, Bo'ness,
EH51 0DH

Date of visit: 1 November 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 Two is a 16-bedded unit which provides assessment and treatment for older adults with dementia. The ward admits both male and female patients. On the day of our visit there was one vacant bed.

We have not visited this ward since 2017. On the day of this visit we wanted to review the care and treatment provided in the ward and hear how patients and staff have managed throughout the Covid-19 pandemic.

Who we met with

We reviewed the care of six patients and spoke with one relative.

We spoke with the clinical nurse manager, the senior charge nurse, and nursing staff in the ward.

Commission visitors

Gillian Gibson, nursing officer

Tracey Ferguson, social work officer

What people told us and what we found

Care, treatment, support and participation

Due to the progression of their illness, we were unable to have detailed conversations with patients; however, throughout the day we introduced ourselves and spoke to ten patients. We observed them to be content and relaxed in the ward and happy to engage with us. We observed supportive and positive interactions between ward staff and patients during our visit and it was evident from these observations and discussions with staff that they were enthusiastic regarding their patients and the care and input that they provided.

Feedback from the relative we spoke to was generally very positive. They described nursing staff as “ace” and “absolutely fabulous”. They felt their family member was more relaxed and comfortable in Ward Two than they had been in previous hospital settings.

Visiting arrangements continued to be supported and we heard that in the summer months, visits were facilitated in the garden area, which was a positive experience for both patients and relatives. At the time of our visit, the ward was in outbreak status due to Covid-19. Therefore, to reduce footfall, visiting took place in a designated visiting room, which is situated outside the main ward area.

This meant relatives and friends do not have access to the ward and were unable to see the ward environment. We heard from staff that they feel this has had a negative impact on relationships with relatives as they are unable to interact with them as freely as they used to and this arrangement has reduced their ability to provide feedback and support.

There was recognition that with this patient group, a high level of support is required with all aspects of their care and treatment, including with personal care, dietary and fluid intake, mobility, physical healthcare and stressed and distressed behaviours. The ward establishment consisted of both registered mental health nurses (RMNs) and registered general nurses (RGNs) which we found positive in supporting the mental and physical health and wellbeing of the patient group. All registered nurses had also been supported to undertake specific training in relation to stress and distress. However, the funded staffing establishment did not reflect the level of care and support the patient group required. The ward tended to use a lot of bank staff to cover staffing shortfalls but had a core group of staff who regularly worked in the ward, to support continuity of care delivery. A workforce planning exercise had recently been carried out and requests had been made for an increase in the staffing establishment.

The senior charge nurse is a full-time post, with only 50% funding which supports direct care. There is now additional funding to support 100% of this post. Funding has also been secured to have a full time band 6 senior staff nurse

Care records

The mental health services in Forth Valley use the electronic system Care Partner to hold information on patient’s care and treatment. However, Ward Two is not currently managed by the mental health directorate. As a result, some documentation is completed on Care Partner and printed off for the nursing notes; which are held in paper format. We found the paper files to be extensive and had difficulty locating specific pieces of information. We heard that there

was consideration being given to moving solely to Care Partner and felt the current practice of working between two systems increased the risk of information being either missing or out of date. We found this to be the case during our visit. This practice also increased the workload of other professionals, as some information had to be recorded twice.

The ward used the Community Hospital and Care Plan booklet which incorporated all physical healthcare assessments required for this patient group. We found this booklet robust and well completed, with a clear focus on individual assessments and requirements for specific care planning.

We found there to be a good standard of record keeping, with regular detailed entries of observations and interactions in the continuous care records. There were sections in the care notes for family dialogue and social work dialogue that provided a detailed overview of communication with relatives, carers and social work colleagues.

Recommendation 1:

Managers should ensure a review of the record keeping system is undertaken to ensure all information is current, up to date and held in one place.

Care planning

The ward used a stress and distress symptom scale which informed specific stress and distress care plans. Overall we found the standard of these care plans to be good, however, we felt some required more detail, specifically in regards to the type of stress and distress experienced; there were detailed interventions recorded as how to reduce this and who was responsible for each intervention. Some files we reviewed had no other care plans in place. It was unclear whether there were additional care plans held on Care Partner as we were unable to access this on the day of our visit. We would have expected to find a range of care plans that addressed mental health and physical health needs, including detailed discharge planning which identified person-centred goals and interventions.

When we reviewed the care plans we were unable to locate robust summative reviews that targeted nursing intervention and highlighted individuals' progress. We would have expected to see a detailed summary of the care plans, documenting what progress had been made to meet specific goals, and which interventions had been effective.

We heard that relatives were not involved in care planning and we were unable to find evidence of relative involvement in the care plans we reviewed. Where patients were unable to fully participate in care planning due to the progression of their illness, we would have expected these to be discussed and agreed with relatives and carers.

Recommendation 2:

Managers should ensure nursing care plans are person-centred, contain individualised information, reflect the care needs of each person, identify clear interventions and care goals.

Recommendation 3:

Managers should ensure that nursing staff include summative evaluations of care plans in patient notes that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Multidisciplinary team (MDT)

The ward had a MDT consisting of nursing staff and a consultant psychiatrist who attends the ward one day per week. There were occupational therapy (OT) staff and physiotherapy staff based in another ward who provided input and support as required. Referrals were made to all other services, such as psychology, speech and language therapy and dietetics as and when required.

There was a robust template for MDT meetings but we found these incomplete regarding who was in attendance. We would also expect to find more detailed actions identified at MDT meetings, particularly for those patients whose discharge from hospital had been delayed.

On the day of our visit, there were 13 patients whose discharge had been delayed. These patients are in a guardianship process and unable to move to care homes. We heard this was mainly due to the availability of appropriate care home placements. However, we heard there were often delays in the allocation of social workers due to staffing shortfalls and increasingly large caseloads of social workers in the Forth Valley area. We were told a social worker from the re-enablement team oversees patients currently awaiting discharge and periodically attended MDT meetings. Of the case files we reviewed, we were unable to find evidence of regular social work attendance at MDT meetings.

Recommendation 4:

Managers should urgently ensure a pathway is developed in partnership with social work colleagues to support timely discharge from hospital.

We heard that relatives and carers were not invited to attend MDT meetings and we were unable to find any evidence of relative carer involvement in the files we reviewed. We were aware that family meetings were held with the social worker in attendance, but these tended to be mainly for discharge planning. We heard that relatives often had to request updates but that the staff were good at providing these when asked. We would hope that relatives and carers would be offered the opportunity to attend MDT meetings if they wished.

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 stored in the case files and were not available in the treatment room where medication was dispensed. We would expect T3s to be easily accessible, to ensure staff dispensing medication were fully aware of any authorised treatment to be given. We found four patients had been prescribed medication which was not authorised by the T3 that was in place. We informed managers of this on the day of our visit.

Recommendation 5:

Managers should ensure that processes are in place to comply with Part 16 of the Mental Health Act and that all prescribed psychotropic medication is legally authorised.

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 (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 Act. Consent to treatment certificates were in order along with accompanying care and treatment plans, which detailed specific treatment covered by the certificate. These were also discussed relatives. However, in some cases, we found that there was a significant period of time between examination of the patient in relation to capacity and the completion of the treatment plans and subsequent discussion with relatives.

There appeared to be a clear process to identify where there was a welfare proxy (guardian or power of attorney) in place; details were recorded and most files had copies of powers in place.

The ward uses a legal document review template which includes information regarding Mental Health Act and AWIA status. We felt this was a good prompt for the MDT, however, the information required to be more specific. It was unclear in some of the templates whether there was a power of attorney or guardianship in place and information regarding Mental Health Act review dates was out of date.

Rights and restrictions

Ward Two operates a locked door, commensurate with the level of risk identified with the patient group. This information was clearly displayed in the ward on the day of our visit.

We also saw evidence of individual risk assessments that linked to the care plans. However, many of these had not been reviewed for several months. Again it was unclear as to whether reviews had been completed on the electronic recording system and not been recorded in the paper file.

We were pleased to hear that advocacy services had resumed face-to-face visits. We heard that patients were referred to advocacy services by staff, but we were unable to find any evidence of advocacy involvement in any of the files we reviewed.

The Commission has developed [Rights in Mind](https://www.mwcscot.org.uk/law-and-rights/rights-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 Two had a dedicated activity co-ordinator who worked closely with the OT assistant. We saw a range of activities taking place on the day of our visit. There was a photo collage at the entrance to the ward with pictures of patients enjoying activities. We heard from the relative we spoke to about a garden party that was held, describing this as “lovely” with the staff going “above and beyond” to make the day special.

The ward uses the ‘Getting to Know Me’ booklet to identify individual likes, dislikes and hobbies and had recently introduced individual activity records. These were used to document

activities offered and undertaken on a daily basis. We suggested creating and introducing individual activity care plans which detailed opportunities for person-centred meaningful activities. We felt these would link well with the stress and distress care plans with the aim to promote wellbeing and reduce the need for pharmacological intervention.

The physical environment

The layout of the ward consisted of 16 single rooms divided between two areas in the ward referred to as wings. Each bedroom had en-suite toilet facilities. There was an assisted shower room and a bathroom in each wing.

Each bedroom had a personalised sign on the door which we heard patients had been supported to choose themselves. There were whiteboards in each room detailing a person-centred life story. However, we did feel that the bedrooms could be more personalised, with meaningful belongings and photographs for each patient.

We found the ward to be relatively bright and spacious. We could see efforts had been made to soften public rooms and make them feel more homely and inviting. There were tasteful pictures on the walls along with sensory stimulating wall mounts to occupy patients around the ward. There was plenty of seating in the two lounge areas, and a separate dining area for the patients. Dementia friendly signage supported orientation throughout.

The ward had access to a large open garden which was wheelchair accessible. There was again plenty of seating, along with a greenhouse and summerhouse which was decorated to reflect an old sweet shop. We heard this was well used in the summer months.

Summary of recommendations

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Managers should ensure a review of the record keeping system is undertaken to ensure all information is current, up to date and held in one place.

Recommendation 2:

Managers should ensure nursing care plans are person-centred, contain individualised information, reflect the care needs of each person, identify clear interventions and care goals.

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Managers should ensure that nursing staff include summative evaluations of care plans in patient notes that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

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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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