Mental Welfare Commission for Scotland

Report on announced visit to: Loch View, Stirling Road, Larbert FK5 4AE

Date of visit: 14 December 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 that is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Loch View is an assessment and treatment ward for adults with learning disability, autism, and complex health needs. Patients are accommodated across three houses. Previously there was capacity for 20 patients but this had recently been reduced to 18 beds to provide additional space for patients with complex needs. On the day of our visit there were no vacant beds.

We last visited this service on 14 January 2020 and made one recommendation in relation to psychology input to the ward. On the day of this visit we wanted to follow up on this recommendation and hear how patients and staff had managed throughout the current Covid-19 pandemic.

Who we met with

We met with three patients, and reviewed the care of seven patients. We also met with one relative and spoke with three relatives by telephone.

We spoke with the consultant psychiatrists, senior charge nurse, charge nurses, clinical nurse manager, art therapist, nursing and domestic staff.

Commission visitors

Gillian Gibson, nursing officer

Kathleen Liddell, social work officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

We received positive feedback from patients, relatives and staff. We heard from relatives that they were happy with the care provided and felt welcomed and involved in care decisions. We heard they felt listened to and communication was "excellent". Staff were described as "brilliant" and patients told us they loved the staff and they were "very nice".

Staff told us there had been a positive culture shift in the ward over recent months, it was a very supportive team and they greatly enjoyed their jobs. We saw warm and supportive interactions between staff and patients throughout our visit and it was evident staff knew the patients well.

One relative told us there had been a number of staff changes since the Covid-19 pandemic and felt this had had an impact on their relationships with staff. Senior managers told us of the longstanding difficulty in the recruitment and retention of nursing staff. We were pleased to hear about the proactive approach that has been taken to address this with exit interviews carried out to identify reasons for leaving, and also of the early recruitment of newly qualified staff. A comprehensive induction programme had been introduced to support staff to gain the knowledge and skills to work with this patient group and a programme of both group and one-to-one supervision had been developed for all staff. The service has recently completed a workforce planning exercise and additional staffing has been requested with the plan to introduce specialist nursing posts to enhance the service provided.

During the Covid-19 pandemic the ward relied heavily on agency staff. This had reduced significantly with the recruitment of newly qualified staff. There was a core group of bank staff who worked in the ward that provided continuity of care delivery.

When we last visited the service we looked at the progress of discharge planning for patients who had been in hospital for lengthy periods. A delayed discharge occurs when an in-patient who is clinically ready for discharge continues to occupy a bed, usually because of delays in securing a placement in a more appropriate setting. We were aware of admissions to the service of non-Forth Valley patients and heard that discharge planning could be more complicated when the adult was out with their own area. We were disappointed to hear that little progress had been made to find appropriate community placements for those patients and agreed that the Commission will write to the relevant Health and Social care partnerships separately.

We heard of the challenges in finding appropriate community placements for patients in Forth Valley which was mainly attributed to staffing shortages with care providers and suitable accommodation. We were pleased to hear there had been some progress in the weeks prior to our visit and active planning was underway for some of the patients whose discharge has been delayed.

Care planning

We found a range of care plans that addressed mental health and physical health needs which were detailed and identified person-centred goals and interventions. Positive behaviour

support plans were incorporated into individual care plans and clearly identified who was responsible for taking interventions forward. We heard that named nurses met with patients weekly to discuss their care plans, but found little recorded evidence of patient involvement in care planning.

When we reviewed the care plans we were unable to locate robust summative reviews that targeted nursing intervention and highlighted individuals' progress. We heard that when there were changes to an individual's care plan, this was rewritten. This made it difficult to see what progress had been made to meet specific goals and which interventions had 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 patient forums took place monthly and were hosted by the speech and language therapist (SALT), music therapist and nursing staff. Talking mats were used to help people with communication difficulties express their views. Every patient was given the opportunity to meet with their named nurse on a weekly basis to discuss wellbeing, activities and care plans.

Multidisciplinary team (MDT)

The unit had a multidisciplinary team (MDT) consisting of nursing staff, psychiatry, occupational therapy (OT), SALT, music therapy, physiotherapy and psychology staff.

Nursing staff continued to provide psychological therapies with supervision and support from the psychologist. When we last visited the service we felt that the patient group would benefit from additional sessions from psychology and recommended managers undertake a review of the psychology service that was provided to the wards. We were pleased to hear that an additional psychologist had been recruited to provide input to the wards but on the day of our visit it had not yet been agreed how much input they will provide.

MDT meetings were well documented and it was clear to see who had attended, the discussions that took place and the identified actions. We were disappointed to see that although all disciplines attended the meeting, often only the nursing summary and report was available in the MDT pro-forma. We fed this back to managers on the day of our visit.

We saw that relatives were invited to meet with the MDT on a regular basis and relatives commented positively on the availability of the psychiatrists.

On our last visit, we suggested using a care programme approach (CPA) for this patient group. 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. We were pleased to see that this had been recently introduced for some of the patients in the ward with a plan to extend this approach to all patients. For those patients who had CPA meetings, these

were clearly recorded with timely outputs covering all key areas. We were pleased to see evidence of patient and relative involvement.

We saw detailed involvement from the OTs and SALT and it was clear to see the benefit these disciplines brought to the care and treatment of the patients. We were also pleased to see regular input and involvement of social workers and mental health officers.

Care records

Information on patients' 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 variation in the standard of record keeping with some detailed entries of observations and interactions in the continuous care records. However, some entries were very sparse and lacked detail, making it difficult to get a sense of how patients spent their day.

We were unable to find detailed recorded one-to-one sessions with patients taking place despite being told these happen on a weekly basis.

Recommendation 2:
Managers should ensure that nursing documentation complies with the Nursing and Midwifery Council record keeping standards, including the recording of one-to-ones.

Use of mental health and incapacity legislation

On the day of our visit, 11 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, (Mental Health Act). Documentation pertaining to the Mental Health Act was accessible and in order. Part 16 of the Mental Health Act 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 were available and in order.

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 found a variation in the details of the treatment plans in the files we reviewed and one patient did not appear to have one.

In the case files we reviewed, where there was a welfare proxy (guardian or power of attorney) in place under the AWAI, details of this had been recorded, however there was not always a copy of the order available on the electronic system. These were kept in paper files in each of the houses. We discussed the importance of all members of the MDT knowing what powers had been granted to the welfare proxy and suggested these be uploaded to Care Partner.

Rights and restrictions

Loch View operates a locked door, commensurate with the level of risk identified in the patient group. Information on the locked door policy was available.

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. Where specified person restrictions were in place, the appropriate documentation was available in the files to authorise restrictions, including evidence of a reasoned opinion.

When we are reviewing patient files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they do or do not want. Health boards have a responsibility for promoting advance statements. The Commission supports 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 found one advance statement in the files we reviewed which was detailed and person-centred.

We observed a patient who the service referred to as being in segregation. We felt seclusion was a more favourable description for this practice. We were informed of and understood the reasons for this level of restrictive practice and were pleased to see that this was kept under regular review by the MDT. There was clear guidance for staff in relation to positive ways to interact and engage with the patient and it was evident that staff were working hard to build a therapeutic relationship with them.

We observed the use of CCTV cameras in the living and bedroom area for this patient. We were told that the purpose of the CCTV was to monitor and observe the patient due to significant clinical risk and was proportionate to the assessed level of risk. We were content that the CCTV was being used appropriately and was not in place of staff contact. We did however query the legislative framework in place to support this, as CCTV could be considered to be an intrusion into an individual's privacy and dignity which is protected under Article 8 of the European Convention on Human Rights. Cameras may be deemed as a threat to an individual's privacy and their use must be proportionate, lawful and legitimate. We discussed this with the psychiatrist on the day of our visit and were satisfied with the response.

We found evidence of consistent advocacy involvement for the majority of the patients and heard how the SCN had developed a pathway for advocacy input in collaboration with the advocacy service manager.

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, OT and music therapy staff. We heard that the ward had a minibus which was used for trips to the local community at weekends. We heard that each house had an activity champion and saw evidence of themed parties that had taken place for patients, relatives and staff. There were individual activity programmes in place for each patient both electronically and in their bedrooms. We found some of these lacked detail of the actual activities identified. We heard that there were a variety of activities offered and patients spoke highly of these, but again we struggled to find evidence of activities offered and undertaken in the care records.

Recommendation 3:

Managers should ensure that all activities that are offered are recorded in each patient's notes, along with the patient's participation/engagement.

The physical environment

Loch View consisted of three individual houses. Houses 2 and 3 had six individual bedrooms with en-suite toilets. House 1 had eight single bedrooms, but the service had recognised the need to create additional living space for patients with significant complex needs. House 1 was under renovation on the day of our visit. We were able to see the plans for this which included reducing the number of beds to six in order to create two enhanced living spaces. Due to this ongoing work, patients from house 1 were temporarily decanted into house 4 which was previously used for MDT meetings and staff wellbeing.

Each house had a living room, dining room, kitchen and quiet room. We found house 2 to be quite stark in presentation, but recognised the clinical need for this due to the complex needs of the patients residing there. House 3 had a cosy feel to it, was softly decorated we were able to appreciate the efforts made to make this feel a homely and welcoming environment.

Bedrooms were personalised and individualised. Patients were supported to pick pictures for their bedroom doors which were meaningful to them. There were also one page profiles in patient bedrooms with individualised person-centred information.

The main reception area had a therapy room, a hub which was used for parties and visiting, a gym, a living skills room, art therapy room, music therapy room and a snoezelen room, which is a controlled multi-sensory room often used for people with learning disabilities, brain injuries, dementia or other developmental difficulties.

Each house had its own large garden space with seating areas and greenhouses. There was also a large garden area in front of the houses and we heard that funding had been secured to transform this into a sensory area which included an outdoor gym, sunken trampoline, raised flower beds and seating areas. We were able to see the plans for this and were impressed with the proactive approach the team were taking to enhance the area for the patient group. We look forward to seeing how this work has progressed 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 nursing documentation complies with the Nursing and Midwifery Council record keeping standards, including the recording of one-to-ones.

Recommendation 3:
Managers should ensure that all activities that are offered are recorded in each patient's notes, along with the patient's participation/engagement.

Good practice

Loch View had introduced a Positive Behaviour Support (PBS) approach with a focus on engagement, active support and meaningful activity. PBS is a person-centred approach to identify and meet a person's support needs, in particular if someone is distressed and at risk of harming themselves or others. PBS is most commonly used to support people with learning disabilities, some of whom may also be autistic. It is based on working with the individual and their support network to understand why someone is distressed, the impact their environment has on them and identify the best way to keep them safe and happy. Four registered nurses had been supported to complete a post graduate qualification in PBS. Supervision was provided by the psychologist. This approach had increased staff understanding of the patients they work with as well as supporting their own wellbeing. Weekly core groups meetings had been established with the MDT. This allowed the team to assess each patient each week, trouble shoot and agree shared goals. This had enhanced MDT working and understanding and appreciation of the unique contribution of each discipline.

Through a training analysis, there had also been a recognition for the need to enhance staff's knowledge and skills in physical health care as a direct result of the Covid-19 pandemic. Ward managers were exploring training opportunities for staff. Staff had also been supported to attend training in safety and stabilisation, keeping trauma in mind and decider skills.

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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