Mental Welfare Commission for Scotland

Report on announced visit to: Ward 3, Forth Valley Royal Hospital, Stirling Road, Larbert, FK5 4WR

Date of visit: 9 May 2023

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 3 was a 21-bedded adult acute mental health assessment, care and treatment ward for males and females. The ward covered the catchment area of Falkirk in Forth Valley. On the day of the visit, there were no available beds.

We last visited Ward 3 on 15 March 2022 and made recommendations in relation to person-centred care planning and meaningful activity. On the day of this visit we wanted to follow up on the previous recommendations as well as look at the care and treatment provided on the ward.

Who we met with

We met with 10 patients, and reviewed the care of nine patients. We also met with four relatives.

Prior to the meeting we met with the senior charge nurse (SCN), charge nurse (CN) and clinical nurse manager via video call. On the day of our visit we spoke with the clinical director, head of mental health nursing and the activity co-ordinator.

Commission visitors

Gillian Gibson, nursing officers

Alyson Paterson, social work officer

Susan Hynes, nursing officer

What people told us and **what we found**

Care, treatment, support and participation

The feedback we received about staff was generally very positive. We heard them described as “great”, “helpful”, “nice” and “kind.” One patient told us that all staff, from domestic staff to the doctors were “top class and all deserve a pay rise.” The majority of patients we spoke to knew who their named nurse was. However, we were also told that staff were very busy and some did not interact with patients. We were told that staff shortages had impacted on how patients approached staff for support and they often did not want to bother them. We also heard it was difficult to keep up with who was who on the ward, due to the number of staff from other wards, bank and agency staff covering shifts.

Some of the relatives we spoke to felt very involved in care and treatment with good communication from nursing and medical staff. Those relatives generally attended MDT meetings each week. The relatives that were unable to attend MDT meetings were not clear as to how they could contribute to meetings and were unsure of future plans, including discharge planning.

Staffing challenges across the mental health site were acknowledged by managers who were actively trying to recruit and retain staff. We recognised this was an issue nationally. We heard that staffing levels in all of the mental health wards were assessed every morning and again throughout the day. Ward 3 staff were regularly deployed to other wards to support safe staffing across the site. Bank staff were regularly used to ensure safe practice on the ward. Wherever possible, bank staff were block-booked to promote consistency, relationship building and enhance patient care. We were told there was a reliance on agency staff across the mental health wards and often agency nurses would be used in Ward 3 to ensure there were adequate numbers of regular staff in all wards.

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 including mental health legislation. 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 the information held in the daily care records variable in detail and quality. Some care records documented person-centred information on how the patient presented throughout the day, but other care records included language such as “visible on the ward” and “keeping a low profile”, making it difficult to determine patient progress on the ward and any achievements or challenges faced. We also saw the word “inappropriate” used in reference to someone’s behaviour, with no elaboration as to what they were doing or why this was deemed to be inappropriate, and to whom. One patient told us that staff often called him “sarcastic” and we saw this word used to describe him in his notes. We did not find this use of language helpful, as it was subjective and could negatively influence how others viewed or treated an individual. We would expect to see a consistent standard of record keeping that was person-centred and detailed personalised information. We discussed this with the CN on the day of our visit and heard how the staffing challenges had impacted record keeping. Bank

and agency staff did not have access to Care Partner which meant the responsibility for completing care records for all patients often fell to one or two regular staff. There were plans to address the standard of record keeping, which included a training session delivered by medical staff on the assessment and documentation of an individual's mental state. We also suggested the use of canned text to act as a prompt for staff as to what they should consider when completing notes.

Some patients told us they had regular one-to-ones with staff but others did not. It appeared that if an individual requested a one-to-one, this was facilitated but patients were not routinely offered these in a structured way. This was consistent with what we found in the notes.

We found the majority of clinical risk assessments to be comprehensive and of a good standard. The risks were clearly recorded with a plan to manage each identified risk. Some held only basic information with yes/no answers recorded with no elaboration.

Nursing staff continued to carry out 'Improving Observation in Practice' (IOP) safety checks. This was recognised by patients as we were told staff regularly 'check in' with them throughout the day. 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.

Recommendation 1:
Managers should ensure that care records are personalised, goal and outcome focussed and provide more detail on how patients present throughout the day.

Recommendation 2:
Managers should ensure patients are regularly and consistently offered the opportunity to discuss their progress on the ward and any concerns they have in structured one-to-one meetings with nursing staff.

Nursing care plans

Nursing care plans are a tool which identify detailed plans of nursing care and effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

When we last visited the service we recommended that all patients should be supported to be fully involved in creating person-centred care plans and participate in regular reviews. All patients should be given a copy of their care plans and evidence of patient involvement should be clearly documented in their notes, including a detailed account of any reasons a patient disagrees with the care plan or chooses not to be involved. We heard that weekly audits had been introduced and the audit carried out prior to our visit indicated 90% of patients had a copy of their care plans however, acceptance rates were consistently low. We saw documented evidence of care plans being discussed with patients and copies offered. However, the vast majority of patients we spoke to did not know what a care plan was. We spoke with the CN regarding the language used when referring to care plans and suggested staff use consistent language to ensure patients are clear as to what a care plan is and the purpose.

We were able to see the efforts that had been made to enhance the standard of care planning in the ward and found the majority of care plans to be person-centred with the use of patient friendly language. However, some care plans appeared to be written to the person as opposed to with them, which led us to question whether the goals identified in the care plans were the patients or the multidisciplinary team's goals.

We were unable to locate summative care plan reviews in relation to progress towards goals and efficacy of interventions identified in the main body of the notes. Reviews were documented on the care plan that were then archived and a new care plan written. This made it difficult to easily and quickly establish what progress patients had made in working towards their care goals and any changes in their care needs. We would suggest including detailed care plan reviews in the care plan contact record.

Multidisciplinary team (MDT)

The ward had an MDT on site consisting of nursing staff, psychiatrists, occupational therapy (OT) staff, psychology and pharmacy staff. Referrals were made to all other services, when required.

Weekly MDT meetings were held in the ward. Professionals involved in an individual's care and treatment were invited to attend the meetings and update on their views and involvement.

A detailed, comprehensive MDT meeting proforma was in use and we found the majority of these fully completed, providing a detailed holistic review with a clear indication of each patient's presentation over the past week. We found detailed plans, outcomes and areas of focus recorded. However, we found some were missing information regarding who was in attendance, patient and family involvement and outcomes of discussions. We would expect to find a consistent standard of MDT meetings ensuring any patient and family involvement is recorded

Patients and family/carers were invited to attend the ward rounds and we saw evidence of their involvement. Since our last visit, the ward and MDT had achieved Accreditation for Inpatient Mental Health Services (AIMS). This is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Accreditation provides assurances of the quality of the service being provided. One of the outcomes was to increase patient involvement and participation. The service had created a pre MDT meeting form for patients to document anything they wished to raise or discuss at the meeting. Some of the patients we spoke to told us they found this beneficial as it helped them prepare for the meeting and acted as a prompt for them during it.

We also saw documented input from OT, psychology, pharmacy and social workers in the care.

Use of mental health and incapacity legislation

On the day of our visit, seven patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The majority of patients we met with during our visit had a good understanding of their detained status.

All documentation pertaining to the Mental Health Act, including full findings and reasons following mental health tribunals was stored electronically on Care Partner and easily located.

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. We reviewed all patients consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We found one instance where medication was prescribed which was not authorised on a T3 certificate and highlighted this on the day of our visit.

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 copies of this in the patient's file. One of the patients we spoke to had identified who they wanted to nominate as a named person but their mental health officer (MHO) had left and they had been advised this was not a priority. We discussed this on the day of our visit and advised that a member of the MDT could support and witness the nomination of a named person and this role did not solely fall to an MHO.

When we were reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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. Health boards have a responsibility for promoting advance statements and we were pleased to find a few patients had advance statements in place on the day of our visit. We were also pleased to see posters displayed in the ward promoting advance statements. We heard that advocacy services were also promoting this with patients and had developed a short video explaining the benefits of making an advance statement. 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.

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 must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. For those with s47 certificates in place, we found these were in order, along with accompanying treatment plans.

Rights and restrictions

Ward 3 continued to operate an open door policy, however the door to the mental health unit required swipe access. Patient access to and from this area continued to be monitored by a staff member seated at the door, noting who was coming and going from the ward, their expected time of return and what they were wearing at their time of leaving the ward. This role was shared by staff from Wards 2 and 3 on a 30 minute rotational basis.

On our previous visits we were told that the creation of an alternative reception area had been planned but work had been held up due to the Covid-19 pandemic. We were pleased to find this work had been completed on the day of our visit, however was not yet operational due a number of small security issues which were being addressed. In light of the significant staffing

difficulties in the wards, we were concerned to hear that staff from Wards 2 and 3 would continue to monitor this area.

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 and where restrictions are introduced, it is important that the principle of least restriction is applied. We found that where restrictions were in place, the appropriate documentation was available in the file to authorise this.

The detained patients we spoke to on the day of our visit had a good understanding of their rights. Advocacy services were available on a referral basis and we saw evidence of advocacy support and involvement in the notes. One of the patients we met with showed us a letter they had received regarding their detention under the Mental Health Act by their Responsible Medical Officer. The letter detailed the patient's legal status, their rights in relation to this and contact numbers to support patients to exercise their rights.

We spoke to a number of informal patients and we were concerned that that they were not clear, nor had they understood their rights as an informal patient. We heard that on admission, they were not allowed to leave the ward for a minimum of 72 hours. Time off the ward was then negotiated at MDT meetings, often starting with escorted time out. We discussed this with the hospital managers on the day of our visit. Although we understood that in order to carry out a full mental state examination and risk assessment, it was preferable to ask patients to remain in the ward for a period of time. However, not explaining their rights to them and failing to obtain explicit consent, could potentially amount to de facto detention. De facto detention is when an individual is in theory free to leave the ward but in practice can not do so.

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

Recommendation 3:
Managers should ensure all patients are fully aware of their rights. Consent must be obtained and clearly documented to demonstrate informal patients are willing to remain in the ward with no time out, should this be deemed to be in their best interest.

Activity and occupation

When we last visited the ward, we made a recommendation that managers should ensure there was a structured, scheduled, activity programme available to patients seven days per week. Unfortunately, due to sickness absence, this work had not progressed. We heard of efforts to provide some level of activity cover in the ward but this had proved difficult. On the day of our visit, the activity co-ordinator for Ward 2 had started and would be providing some coordinated activities to patients in Ward 3.

There was an OT who covered several of the mental health wards and who provided assessment on focused activities. We heard an art therapist attended the ward weekly and we

saw pet therapy taking place on the day of our visit. We heard and saw how much both staff and patients enjoyed this.

Almost every patient we spoke to raised concerns about the lack of meaningful activity in the ward and spoke about feelings of boredom. We heard that nursing staff tried to offer activities where they could and materials had been made available to support this. Quizzes, bingo and walks were offered but these activities were not of interest to the patients we spoke to.

We also heard that due to staffing difficulties, patients were not able to access the gym. We heard that patients had to go off the ward and pay for memberships at local gyms. We raised this with the CN and heard only the activity co-ordinator and one healthcare support worker were trained to support patients in the ward gym. This had been raised on previous visits with recommendations made. We were disappointed to hear this issue remained unresolved.

Recommendation 4:
Managers should ensure there is a structured, scheduled, meaningful activity programme available to patients seven days per week. Managers should also ensure activity participation is recorded and evaluated in individual care records.

Recommendation 5:
Managers should ensure that there are adequate numbers of suitably qualified staff available to allow patients flexible access to the gym.

The physical environment

The layout of the ward consists of 21 single room, 14 of which had en-suite facilities. Two of the rooms were designed for patients with disabilities and were fitted with assisted technology. There was also an annex to support perinatal admissions with a small sitting area and a room to facilitate visits available. Some of the patients told us that the showers in the en-suites were not very good as they did not have taps, but instead a push button that required constant pressure. We heard the communal showers were much better but there were not enough available for all the patients in the ward.

There was a lounge area and a separate quiet area. We heard the television was not working properly and only one channel was available for viewing. We were assured this would be fixed. On our last visit the shared dining area was not being used due to Covid-19 restrictions. We were pleased to see this was in use again on the day of our visit.

The ward was bright, spacious, clean and tastefully decorated. There were a number of rooms available for quiet space and visiting. Patients told us how much they appreciated the family friendly visiting room which had activities for young children to play with during visits.

Staff and patients had created a ‘thankful tree’ in the sitting room, which was used to create positivity and highlight things people were thankful for. We heard there were also plans to create a sanctuary room which patients had been consulted about. We look forward to seeing how this work progresses.

There was a laundry room available for patient use which was open at all times and an OT kitchen. We were disappointed that there were no provisions for patients to make themselves hot drinks or snacks throughout the day.

The ward had an enclosed garden which was large and well maintained. Again, we heard how much patients appreciated this space.

Summary of recommendations

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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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