Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 1, IPCU, Forth Valley Royal Hospital, Stirling Road, Larbert FK5 4WR

Date of visit: 11 October 2023

Where we visited

Ward 1 is a six-bedded intensive psychiatric care unit (IPCU) with capacity for two further contingency beds. It provides assessment and treatment for adults who experience mental illness and behavioural difficulties, and present with increased clinical risk that requires elevated levels of observation. On the day of our visit there were three vacant beds. There was a multidisciplinary team (MDT) consisting of nursing staff, a consultant psychiatrist and pharmacy provision. There was no occupational therapist (OT) or other form of activity resource allocated to the ward.

We last visited this service on 19 April 2022 and no recommendations were made. On the day of this visit we wanted to hear of patients and staff views of care and treatment in an IPCU setting.

Who we met with

We met with three patients and reviewed their notes on the electronic system 'Care Partner'. We were unable to interview any relatives or carers and the patients we spoke with on the day told us that they did not have contact with relatives.

Prior to visiting we had an online meeting with the service manager (SM), the senior charge nurse (SCN), the clinical nurse manager (CNM), the deputy senior charge nurse (DSCN) and the consultant psychiatrist. The clinical lead attended the feedback meeting later in the day along with the SM and SCN.

Commission visitors

Denise McLellan, nursing officer

Gillian Gibson, nursing officer

What people told us and what we found

Care, treatment, support and participation

We were pleased to hear from two of the patients that staff were "great" and that they felt "listened to", describing them as "friendly and helpful". Although they were aware of having a named nurse allocated, unfortunately they were unable to tell us who they were. We were however aware that an individual's mental state and the recent admission to the ward may have been contributory factors.

Another patient who had been admitted for a longer period told us that they were unhappy being cared for in a separate corridor from the other two patients. We spoke with the SCN about this, who informed us that this had been to manage risk in the ward, and as a safeguard for patients in the environment. We had concerns that there were additional restriction in place for this patient, without any legal authority to do so; we raised this with managers on the day.

Patients also told us about the lack of things to do, and the lack of activity. We heard from one of the individuals after our visit, who phoned the Commission's advice line to suggest what they felt may be helpful. Their suggestions included access to television or radios in bedrooms, and that art therapy should be essential.

Nursing care plans

When we last visited, we found examples of detailed, person-centred care plans which addressed the full range of care for mental health, physical health, and general health and wellbeing of the individual. Entries were detailed; however, we still noticed some phrases such as "evident on the ward" but it was clear from the mostly detailed entries that the patients' mental state was being assessed on an ongoing basis.

We were pleased to see that care plans continued to be holistic, identifying interventions for both nursing and medical staff however, the language did not demonstrate evidence of collaboration with the patient. The language used was directive, and included words such as "you have" and "you will". Care plans had not been agreed or signed by the patients, although documentation was recorded as to why this had not been achieved, with an example noting that the individual had a lack of insight at the time the care plans were written. We suggested that care plans could be discussed with the individual at a time where their mental state had improved.

Regular reviews were being carried out and recorded but there were limitations to accessing information easily in relation to progress achieved, due to them being written on historical care plans and having limited access to these.

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

Multidisciplinary team (MDT)

There were detailed MDT meeting notes that evidenced those involved in an individual's care and treatment, and who were invited to attend the meetings and provide an update. This also included patients and their family/carers, should they wish to attend.

The MDT template meeting was comprehensive, evidencing a holistic overview of patients. It is reassuring to see the Broset Violence Checklist Tool now embedded in practice. National Early Warning Score (NEWS) and nursing care plans were reviewed at each meeting. The MDT template included sections for legal status, consent to treatment certificates, specified person status, care programme approach (CPA), high dose monitoring (HDM) and risk status, including risk of deliberate and accidental self-harm. We did however note that disciplines who attended were only from nursing and psychiatry, with pharmacy provision and mental health officers (MHOs) attending when required. Ward 1 previously had access to a part-time occupational therapist, with an additional twice weekly input from an activity coordinator, so it was disappointing to learn that this resource had not been reinstated following maternity leave and staff retirement. There was also no psychology, although we were told this was being addressed with interviews taking place in the near future. We heard that psychology provision will be shared across the adult mental health wards on the site.

Care records

Information on patients care and treatment was held on 'Care Partner' electronic record system, which was relatively easy to navigate. Risk assessments were completed using the functional analysis of care environments (FACE). We saw that they were updated weekly, and again after the MDT meeting a record was added to Care Partner.

Use of mental health and incapacity legislation

On the day of our visit, two individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act), and one was subject to detention under the Criminal Procedures (Scotland) Act 1995. One individual had a Mental Health Tribunal for Scotland (MHTS) hearing via phone call in a side room of ward. The patients we met with understood they were subject to detention under the Mental Health Act. All legal documentation was in place in the electronic files and was up-to-date.

Part 16 of the Mental Health sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. One patient was approaching the two-month period where a certificate authorising consent to treatment would be required. This was discussed with SCN who agreed to confirm whether the required actions were in place to ensure that treatment could continue to be provided lawfully. The other treatment certificate we reviewed was in order.

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. None of the patients had chosen to nominate a named person during this admission.

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. One patient was made a specified person in relation to telephones and restrictions were in place. We found copies of the RES 1 and RES 3 forms and a reasoned opinion was in place.

Rights and restrictions

The ward continued to operate a locked door, commensurate with the level of risk identified in the patient group, which also admitted persons detained by the criminal justice system under the Criminal Procedures (Scotland) Act 1995 (Criminal Procedures Act). We were told that patients always had access to their bedrooms unless they requested staff to lock their rooms while they were off-ward.

When we review patients' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and s276 of the Mental Health Act and are 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. None of the patients in Ward 1 had an advance statement. However, we appreciated that patients on this ward are generally acutely unwell and the time for complete of advance statements may not be ideal; however, we suggested that when someone has capacity to complete one, this should be reviewed during the admission.

There was access to Forth Valley Independent Advocacy for detained patients and the patients told us they had been referred to this service and had met with an advocacy worker.

We had concerns regarding one patient who was being cared for in a corridor separate from the others on the ward. The Commission visitors discussed with the staff on the day that this could be considered to be seclusion, and that providing care in this way could be considered a form of environmental restraint, as the patient was prevented from leaving the corridor. There were a number of concerns that we observed and that we discussed with senior staff including the restricted access to the garden area that was required for all patients, as was access to the dining area, and as a result, patients were having meals in their bedrooms. The individual did not have en-suite facilities, so had to access facilities across the corridor from their bedroom, and an additional room was being used as a lounge with television.

We found no evidence of care planning with reference to decision-making around these actions or consideration of the impact of patients' rights. This decision for this approach to one individual's care, that was having an impact on the ward appeared to have been made without a fuller MDT discussion. We raised this with senior managers who appeared unaware of the situation, and we were reassured this would be investigated further.

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

On our previous visit the ward there had input from an activity coordinator, as well as music and arts therapy and part-time occupational therapy. On this occasion, we were concerned to

find that there was no activity provision. Patients had access to some gym equipment in a room adjacent to the main day area, but it was busy, as was also used as a lounge/games room. We did observe that one patient had been provided with some art material by nursing staff. We heard from those that we spoke with about the lack of activity and how it could lead to boredom.

Nursing staff also raised concerns about lack of meaningful activity for patients and the subsequent impact on the ward milieu. We were told that following the activity coordinator's retirement there had been no input to the ward. They spoke of patients becoming bored from having "nothing to do" and how this could lead to agitation and aggression. We were noted that no activities were indicated on the designated activity board. It listed once weekly 'therapet' and 'long lie-ins' for Saturdays and Sundays. We were told that the patients enjoy and look forward to the therapet visits. We did observe one health care assistant (HCA) sitting with a patient encouraging them to use colouring books and pens.

Recommendation 1:
Managers must ensure there is a structured, scheduled, meaningful activity programme available to patients that is person-centred, offering a variety of activities specific to individual care needs and reflecting patients' preferences. Activity participation should be recorded and evaluated in the individual care records.

The physical environment

When last visited, the ward was described as bright and spacious with comfortable seating however on this visit, we found it to be stark, clinical and cold. Other than two small pictures on the wall in the day area, there was little to soften the overall appearance. Murals were no longer on display and we were told they had been pulled down and there had been a lack of effort to explore more permanent options. Staff described the environment as being akin to "the poor house". We discussed this with the managers, who agreed to explore this further.

The layout of the ward consisted of two corridors with single bedrooms. There was a lounge area and a separate dining area for the patients. The dining room not in use on the day of our visit due to clinical issues described earlier in the report. A temporary dining room was in use. We noted some mould along the bottom of the wall panels in some bathrooms and were told remedial work continued, but there was no timeframe for completion. We were also told of delays due to the building being privately owned, however discussion between the estates department and SERCO was ongoing to have work progressed.

There were plans to remove the concrete slabs in the courtyard garden to make it more therapeutic and soften the area. There was only one bench but given that ward has capacity for eight, this was insufficient. At the feedback meeting we were told additional seating was being sourced. We also enquired about the programmed anti ligature work and were informed this was regularly risk assessed and that there was regular discussion about improvements. The bedrooms were clean but of a basic standard; patients could choose to personalise with pictures and some personal belongings if they wished. Future planning for unused rooms was still under discussion.

Recommendation 2:

Managers should address the environmental issues in relation to maintenance and consider softening the ward appearance with an aim of improving the general ambience of the ward environment.

Any other comments

Concerns were also raised by staff about feeling unsafe on the ward and unsupported by the wider service. They reported feeling that there was a disconnect between managers and some of the staff group; we heard that some felt as though there were two distinct teams. We were told that there was a lack of supervision, management support and debriefs following challenging incidents.

We were told there had not been regular staff meetings for some time. One staff member acknowledged that they had not approached managers directly to raise concerns prior to our visit. We had asked about supervision during our pre-visit meeting and were informed that there was no scheduled programme however, the DSCN and SCN were visible on the floor and could be approached with any concerns. What was positive to hear was that staff felt that there the peer support between the band 3s (HCA's) and 5s (staff nurses), and told us that this is what them "kept them coming to work".

However, we were told that there could be challenges when agency staff were used, as they do not always have access to the hospital electronic prescribing and medication system (HEPMA). We were told of a general decline in staffing numbers and concerns regarding recruitment and retention.

Recommendation 3:

Managers should provide regular managerial and clinical supervision to staff to give them an opportunity to reflect and discuss any issues or concerns they may have.

Summary of recommendations

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Recommendation 2:

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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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