Mental Welfare Commission for Scotland

Report on unannounced visit to: Hope House, Bellsdyke Hospital, Bellsdyke Road, Larbert FK5 4WS.

Date of visit: 5 December 2023

Where we visited

Hope House is a six-bedded low-secure female unit in Bellsdyke Hospital; it provides treatment, support and rehabilitation for women with complex mental health care needs who require an enhanced level of support and supervision. The unit also has access to self-contained bungalows in the hospital grounds for the purpose of rehabilitation to support discharge to the community. On the day of our visit there were no vacant beds.

We last visited in August 2022 and made recommendations about the ward culture and environment. We were told that training had been undertaken to improve relationships and communication between individuals and staff. Systems were reviewed to improve the timescales for outstanding repair work, however, issues such as the repurposing of rooms and provision of ensuite facilities had not yet been completed. We were told that a programme of works had been established and plans for larger scale refurbishment would be undertaken as part of the wider Bellsdyke site refurbishment.

Who we met with

There were five individuals in the ward with one other residing in one of the bungalows. All were asked if they wanted to meet us and we were able to speak with two of them and reviewed the care records of four.

As this visit was unannounced there was no opportunity to meet any relatives or carers. We were able to speak with the senior charge nurse (SCN) and other nursing staff and had a virtual meeting at the end of the visit with the service manager (SM), clinical nurse manager (CNM), responsible medical officer (RMO) and psychologist.

Commission visitors

Denise McLellan, nursing officer

Lesley Paterson, senior manager (East team)

What people told us and what we found

Care, treatment, support and participation

The feedback given by the individuals we met was positive regarding the ward environment and staff, highlighting the level of care and support received. One individual offered praise regarding improvements in the way nursing staff related to individuals and how they felt more respected and less judged about behaviours arising from their illness. They remarked that daily, at least one member of staff routinely checked on their wellbeing and more frequently during incidents that involved challenging behaviour from others. This individual said they felt more included since the introduction of weekly community meetings where individuals discuss activities and had an opportunity to raise and discuss any ward issues. They also told us that they felt informed of their rights and although not currently using independent advocacy, had done so in the past. An improvement in the timeliness of repairs being actioned was acknowledged, saying that most issues were resolved on the same day. It was also noted that there was plenty to do both on the ward and on the wider site provision.

Another individual did however express some disappointment at what they described as the lack of psychology resource to the ward. They had hoped to access dialectical behavioural therapy (DBT) but were able to reflect that some progress had still been achieved over the past year despite this. Another issue was the lack of family work, with one saying that behavioural family therapy (BFT) was raised by their consultant psychiatrist at a care programme approach meeting (CPA), however this had not been delivered. They were still keen to consider it as they felt it would be beneficial for their family and were not aware their family could be offered information about carer's groups in the community. Research has shown that family work can help to reduce carer stress and provide education about illness. Both commented that they liked their RMO, however would like more frequent one-to-one reviews with them and felt they did not see them out with meetings where other professionals were present.

Recommendation 1:
Managers should promote meaningful engagement with carers and relatives where appropriate and signpost them to local carer's groups. Family work should be pursued, where it is considered clinically appropriate.

Nursing care plans

We were pleased to see that care planning continued to be of a good standard and found numerous comprehensive care plans. It was clear from one that the individual had been involved in the discussion as documentation referred to their lack of consent about the community reintegration plan, but we saw that other plans appeared to have been written by nursing staff, with no evidence of the individual being involved in developing them. One noted that it would be discussed with the individual when available, however we were unable to find a signature or other documentation to suggest that this had been done since being written in July 2023. We were told that there was a facility to upload the signature and provide a printed copy and we felt this may be helpful for individuals to have.

The continuation notes evidenced discussion and support offered to one individual, and helpful steps and behavioural changes required to enable this individual to have specific items

returned to their room. There was clear evidence of ongoing assessment of mental health and one-to-one sessions were carried out a minimum of twice weekly. One with a staff nurse and the other with a clinical support worker.

Recommendation 2:
Managers should ensure that care plans evidence individuals' participation in their development and review.

Multidisciplinary team (MDT)

The MDT consisted of nursing staff, one consultant psychiatrist, occupational therapy, clinical psychology and referral can be made to other disciplines, such as dietetics, or physiotherapy, where this is considered appropriate. We accessed several completed MDT meeting templates and found them to be very comprehensive, that included areas to record who attended and who was responsible for feeding a summary back to the individual following the meeting. Additionally, summaries were prepopulated by nightshift staff documenting the individuals' wishes for discussion at the meeting. There was a lot of detail, however we were told that not every section was routinely reviewed, and it could be adapted better to fit the ward. This was one of the items which will be considered in the proposed clinical model review in the coming year. We saw that individuals and carers were invited to the meeting, but we were told by some individuals that this was the only opportunity for them to meet with the RMO. Although this is the main opportunity to meet with the RMO, the staff told us that one-to-one meetings can take place at the individual's request and if clinically indicated. These one-to-one meetings are now being formalised to occur on at least a monthly basis.

The MDT meetings were held off the ward and we saw that individuals were invited to the fortnightly MDT meetings, providing they were clinically stable enough to do so. There were also notes on activities and contact with families. All individuals were managed under the care programme approach (CPA) and documentation was available. 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.

Care records

Care records were held on the electronic system 'Care Partner'. It was relatively easy to access the documentation, but as we have noted at other sites, this system does not lend itself well to a clear chronology of progress due to having to navigate between historical and current information. The functional analysis of care environments (FACE) risk assessment was available in the electronic records and individualised risk alerts were visible on selection of each care record. There was comprehensive documentation for legislation, diagnosis, physical health monitoring and current care plan including details of suspension of detention. Nursing staff also had access to the Hospital Electronic Prescribing and Medicines Administration system (HEPMA).

Use of mental health and incapacity legislation

On the day of our visit, all six individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The individuals we met understood their detention status and up-to-date legal documentation was in place in the electronic files.

Part 16 of the Mental Health Act (sections 235 to 248) sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We noted some issues with authority for medication and highlighted discrepancies in three certificates authorising treatment (T3). One consent to treatment certificate (T2) recorded an individual consenting to receive a different antipsychotic medication to that what was prescribed. The T2 also included an 'as required' intramuscular medication for agitation. Our view is that an individual is very unlikely to be consenting to intramuscular medication for agitation at the time it is felt to be urgently necessary, so this should be authorised on a T3 certificate instead. There was no consent form attached to one T2 certificate and the writing was illegible.

One individual had two T2 certificates written one week apart, but neither fully corresponded to the prescription kardex. A further individual had been prescribed an 'as required' hypnotic which had not been authorised by the treatment certificate. We discussed these issues with the team and were made aware that not all consent to treatment certificates had been completed by the current responsible medical officer (RMO). We highlighted to the nursing staff that they also need to check that medication is legally authorised before administering, and that treatment certificates should be reviewed as part of regular treatment audits.

Recommendation 3:
Managers and medical staff should ensure that all prescribed psychotropic medication is legally authorised and that compliance with this is regularly audited.

Rights and restrictions

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 an individual is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit, no one was subject to specified persons restrictions or any level of continuous intervention. Hope House continued to operate a locked door commensurate with the level of risk identified for this individual group.

All individuals have access to Forth Valley Advocacy and we saw in the notes that one had recently used this service to attend an MDT meeting. Another told us that they had previously accessed this service and would again if they felt it was needed.

When reviewing the files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 to 276 of the Mental Health Act and written when a person has the capacity to make decisions about treatments they do or do not want should they become unwell in the future. Health boards have a responsibility to promote them. We saw in some notes that advance statements were being discussed and promoted by nursing staff with the discussion date recorded and further stating that this would be regularly reviewed, however this was inconsistent, as we found two examples where nothing had been recorded. We discussed this with the SCN, and she was surprised to hear this as it had been an area where there had been additional focus.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals 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

We were pleased to hear that daily meetings to discuss and complete the activity planner were ongoing and were told of continued individual participation. The completed planner was displayed on the ward notice board. In addition to this, there were weekly community meetings to facilitate the discussion about any concerns individuals may have had about the ward and we got a sense that individuals really valued these opportunities to be involved and listened to.

There was a good level of activity provided by occupational therapy and nursing which included cooking, bingo, making Christmas decorations, which we could see had been used to decorate the ward. Individuals could also access to the gym and other recreational activities in the wider hospital setting.

During our visit we observed the Christmas quiz being facilitated by the SCN. We were able to see how well the individuals participated and benefitted from this activity and seemed relieved that it was not disrupted too much by our visit.

There was a therapeutic kitchen on the ward where individuals were supported to plan, prepare, and cook their evening meals. They were provided with a £15 weekly budget to buy groceries over the seven days. They also had access to some staple ingredients to supplement their meal planning. Breakfast and lunch were provided by the service.

The physical environment

The unit was clean and brightly decorated with a variety of tapestries and Christmas decorations. There were several large whiteboards with one displaying ground rules that appeared to have been written as an aide memoire following discussion about respectful behaviours. Another was decorated to include the names of individuals and staff working in the unit. It was informal and friendly with associated nicknames written. These features enhanced the environment and made it personalised and inclusive.

Following one of the recommendations made last year, timescales for repair and maintenance work did appear to improve, however there was still some work outstanding. We were told that one of the two showers in the ward was out of use and that estates had been trying to source a part. One of the individuals told us that the shower had been out of use for months. This was not ideal given that there were no ensuite facilities in the bedrooms and the ward was at capacity. The SCN discussed this with the estates manager who was on the ward during the visit.

The communal areas were bright and colourful, but we found the therapeutic space to be limited and the walls were also thin, so did not afford much privacy. There was also a small ‘quiet room’ in the ward that was being used for one-to-one discussion and was kept locked out with these times. The activity room was used to store equipment, so activities took place

in the main lounge area. Generally, there was a lack of meeting rooms, so we were told that meetings such as CPAs and MDTs must take place off the ward, which staff acknowledged was far from ideal. We were advised that there was ongoing discussion, and this may be rectified as part of further site improvements and that sound proofing could be considered.

There were six single rooms with a sink in each. Bedrooms had been personalised and we were told by individuals that they liked their living space. We noted that there were ligature points in the bedrooms and toilets. We enquired *a*bout the programmed ligature work and were informed this continued to be regularly risk assessed and that there was ongoing discussion about improvements. New windows had been fitted the previous day and new blinds were due to be fitted.

Storage issues had been highlighted previously but this was rectified by provision of a hut outside in the garden. We were told that the garden area was popular and well used in the summer months, but during our last visit it was pointed out that it was overlooked on one side by a neighbouring ward. We noted that the fencing has not been adapted to rectify this.

Recommendation 4:
Managers should ensure a programme of work with identified timescales to address the environmental issues, including anti-ligature work and repurposing of communal areas.

Any other comments

Staff and individuals were all positive about the ward leadership, and we were pleased to hear that regular supervision was taking place for nursing staff. It was also reassuring to note that improvements have been made in relation to culture and values and how this had benefitted individuals' care and treatment.

Summary of recommendations

Recommendation 1:
Managers should promote meaningful engagement with carers and relatives where appropriate and signpost them to local carer's groups. Family work should be pursued, where it is considered clinically appropriate.

Recommendation 2:
Managers should ensure that care plans evidence individuals' participation in their development and review.

Recommendation 3:
Managers and medical staff should ensure that all prescribed psychotropic medication is legally authorised and that compliance with this is regularly audited.

Recommendation 4:
Managers should ensure a programme of work with identified timescales to address the environmental issues, including anti-ligature work and repurposing of communal areas.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk