Mental Welfare Commission for Scotland

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

Date of visit: 9 January 2024

Where we visited

Ward 4 is a mixed-gender dementia assessment unit, primarily for adults aged over 65. The bed numbers had already been reduced to 16 single, ensuite bedrooms prior to our last visit, and have remained at this number. The ward was at capacity on the day of our visit.

When we last visited in April 2023, recommendations were made in relation to person-centred care planning, and relative and carer involvement. We wanted to follow up on this up by accessing care records and through discussion with team and individuals (where possible).

Who we met with

Despite the visit being unannounced, we were able to meet with one patient's family on the morning of our visit. Due to the progression of people's illnesses, we were unable to have any in-depth interaction with individuals on the ward although we reviewed eight care records on the electronic information system 'Care Partner'.

While there was a high level of activity on the ward, we were still able to meet with nursing staff, the assistant psychologist, the occupational therapist (OT), and one of the consultant psychiatrists to discuss aspects of care and treatment.

A representative from Forth Valley Independent Advocacy who was visiting the ward also spoke with us.

Commission visitors

Denise McLellan, nursing officer

Anne Buchanan, nursing officer

Kathleen Taylor, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

The family we met with highly commended the ward team and singled out their relative's named nurse as "top class". They expressed their relief at being able to discuss any concerns they may have had with the wider nursing group saying, "they take time with you" and "couldn't be any nicer" and "I take my hat off to them". They appreciated being told that it was "lovely to see you" and said they felt the environment was pleasant and inviting. Information had been shared with them that they found helpful. They spoke of regular contact with the ward via phone calls two to three times weekly. In general, they described the care as good, and being delivered in a calm environment, where people seemed generally settled and were observed as being treated as individuals by attentive staff. Their only concern was their awareness that their relative could not remain there in the long term; they confirmed that information and support had been offered to them regarding this.

We heard that ward routines were as flexible as possible, with visiting permitted outwith the protected mealtimes and additional flexibility for families to eat meals with relatives if this was beneficial to their care. Information about this was provided and we saw welcome packs available at the entrance to the ward.

The advocacy representative told us they had visited for 19 years and were extremely positive about the ward and team, who were described as helpful and informative and that they provided individuals with an excellent standard of care.

In response to the Commission's last visit to the ward, where a recommendation was made about improving carer engagement, we heard that the assistant psychologist had undertaken a specific project to look at this. The staff provided us with details of its aims and findings and were planning to consult staff and carers on proposals for improvement. We were pleased to hear about this example of collaborative working and look forward to finding out which areas have been identified for further development as they would benefit everyone involved.

We met one consultant psychiatrist who spoke enthusiastically about family/carer involvement. They described the use, and impact, of open dialogue that had worked well in another clinical area and gave an example of how honest and open discussion could be helpful for individuals and their families and carers. Although they acknowledged that some progress had been made in Ward 4, this was viewed only as a starting point and the team were keen to get this right. They spoke about good practise that they had seen elsewhere, and their aspiration to replicate this in the ward.

We were pleased to hear that staffing levels had improved since our last visit and were told that managers had worked hard to recruit newly qualified staff nurses although recruitment was an ongoing issue. Two of the nursing team had received training in the psychological stress and distress model however, as both were leaving imminently, managers were in the process of identifying and planning for further training.

Care records

We found detailed risk assessments available that used the functional analysis of care environments (FACE) document, and these had been updated regularly. Stress and distress formulations had been completed by the assistant psychologist; these were detailed, with a clear understanding of an individual's presentation, triggers and strategies to support them.

Assessments were thorough, detailed and holistic as were the medical reviews, which had recorded actions and planning. The 'Getting to know me' document had been used and provided a valuable source of information about individuals, from those who knew them well. We were pleased to see the use of this document given the usefulness of the information to support the individual in moving on to another care setting. It was also positive to see evidence of their use in care planning. There was helpful information of people's strengths and needs, and we found that care was documented took account of risk assessment and management plans.

Nursing continuation notes were of a good quality, with evidence that staff knew the individuals well; observations of each person showed caring attitudes and empathic care, although we did note the use of some comments, such as "invasive and offensive in conversation" and "became defensive when reminded this was not appropriate". We raised this isolated case with managers who agreed to progress this. Overall, the continuation notes were very detailed with a clear focus on physical and mental wellbeing. One-to-ones were not documented in this format due to the level of cognitive impairment and associated communication challenges with this patient group, however, we found that the continuous notes offered a good explanation of interventions and of individuals' presentations.

Nursing care plans

A recommendation for our last visit was that care plan reviews were to be more meaningful, to include the effectiveness of interventions and to reflect any changes in an individual's care needs. We were pleased to see an improvement in the care plans, which we found to be of a high standard and regularly reviewed. They had a defined psychological focus, particularly relating to cognitive functioning and impact upon wellbeing and symptoms of dementia. We found that where there was a power of attorney in place, we considered that it would have been helpful to see evidence of where the proxy had participated in the drafting of the care plan, as this was difficult to see from our review of the records.

We were pleased to see there was a stress and distress protocol in place, and clear documentation about triggers for stress and distress with interventions and the outcomes of these. Other care plans included physical health, medication, loss of autonomy and rights and restrictions including powers in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Multidisciplinary team

The unit had a multidisciplinary team (MDT) consisting of nursing staff, psychiatry, occupational therapy (OT) staff, pharmacy, psychology, and physiotherapy who were either based there or accessible to individuals. Referrals could be made to other services, such as speech and language therapy and dietetics, as required. The MDT met on a weekly basis. We were told that representatives from social work did not attend every MDT meeting but would

at relevant stages of an individual's progress. Families were not invited to the formal meeting but could attend separate family meetings, where carers' views were considered and discussed at the full MDT meeting. There was evidence in the notes of phone contact with carers where their views were sought for this purpose. We noted on occasion that the attendees at meetings were not always listed. However, in general, the MDT records had detailed reviews, with progress updates and plans for ongoing care and treatment and who was to take the action forward. There was also a good focus on physical wellbeing, with involvement from the dietitian.

We heard that following comprehensive assessment of needs and optimised care and treatment planning, individuals were transferred to either local community hospitals or care homes. Unfortunately, due to challenges elsewhere in care settings and services, this could be a lengthy process. We were advised that due to the severity of their illness, individuals were rarely able to be discharged back home.

Use of mental health and incapacity legislation

On the day of our visit, 14 individuals were detained under the Mental Health Act. Documentation was up-to-date and easy to find in the electronic files. Copies of relevant paperwork was available in both electronic and hard copy format.

Sections 235 to 248 in part 16 of the Mental Health Act set out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We reviewed all certificates authorising treatment and found these to be in order. Section 76 of the Mental Health Act requires the preparation of documented care plans for people who are subject to compulsory care and treatment. There are various points throughout a compulsory treatment order (CTO) or compulsion order (CO) where there is a formal requirement for a care plan to be produced or amended. On reviewing a sample of records, we saw evidence of s76 care plans in the medical notes that were detailed and had outcomes for future planning in relation to the long-term placement that was required.

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 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. Section 47 consent to treatment certificates were in place, with accompanying treatment plans, except for one that required review; staff agreed to take this forward.

Where medication was administered covertly, we found evidence of good practice in that the covert pathway was in use and was regularly reviewed or discontinued as needed.

When someone is no longer able to make decisions about their own welfare, a court can appoint someone to make decisions for them. This person is known as a welfare guardian and can be a partner, family member, friend or social worker. Copies of welfare guardianship orders and power of attorney certificates under the AWI Act were available, and staff were aware of the requirement to remind carers of the need to provide the ward with a copy. This information was also included in the ward welcome pack.

Where 'do not attempt cardiopulmonary resuscitation' certificates (DNACPR) were in place, we found that some had no review date or requirement for review completed. We were aware they had perhaps been written elsewhere, such as in an accident and emergency department. We advised staff that this should be addressed, and nursing staff agreed to follow this up.

Rights and restrictions

None of the individuals detained on the ward were subject to any additional restrictions on the day of our visit. There was a locked door policy in place, which was commensurate with the associated level of risk and each person had a care plan in relation to this. Additionally, further information was documented in the ward welcome pack.

We saw that individuals had regular access to independent advocacy during their admission to the ward.

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.

Activity and occupation

A variety of therapeutic and recreational activity was provided by the OT department. We were told that in addition to two full days from the OT, there was also a part-time activity co-ordinator and a full-time OT support worker. Activities available included music sessions with light exercise, balloon, and pool noodle exercises. For the less mobile, there was mindful colouring, listening to music, board games, and life stories activities offered. There was also access to the kitchen to engage in reminiscence with 'a cup of tea and a blether', where non-cooking items could also be made, such as rice krispie cakes. We were told that activities were mostly ad-hoc, following communication with nursing staff at handover in accordance with an individual's presentation on a given day.

We were pleased to hear that funding had been secured for monthly sessions from Music in Hospitals & Care.

The physical environment

The ward is circular in layout and was well decorated with age-appropriate artwork on the corridor walls, however there was little to distinguish individual bedrooms. The environment was a clean and bright, with a pleasant ambience; it was complemented by a lovely dementia friendly garden.

White boards were available in all bedrooms with helpful 'Getting to know me information'. We were informed that money was being invested to further improve the ward layout and facilities. There were plans approved to create an airlock, where its purpose was twofold. In addition to increasing security and reducing the risk of absconding, it was hoped that by adapting the appearance of an obvious exit, this would reduce the distress for people attempting to leave the ward.

A sensory room was available for use in de-escalation and palliative care. It was recognised there was an overlap in these areas and that benefits could be achieved for both. Other plans that were in place were for changing the MDT room into a lounge, as this was considered to

be a better use of space. For this to be realised, the team has to look at repurposing other rooms and possibly introducing a booking system for areas that were only used intermittently.

It was evident that the team were investing in the environment, the patients, and staff.

Any other comments

We found Ward 4 staff to be a dedicated, caring and cohesive team. Their commitment and dedication to high quality care was evident during our visit and following on from our visit recommendations made last year, they had been proactive with seeking change and improvement. Their efforts have been recognised as they achieved the Royal College of Nursing (RCN) Scotland Nursing Team of the Year Award in 2023.

Summary of recommendations

The Commission made no recommendations; therefore, no response is required. However, we would like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. We will contact the service in three months' time to gather feedback about this.

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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