Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 2, Forth Valley Royal Hospital Stirling Road, Larbert FK5 4WR

Date of visit: 23 April 2024

Where we visited

Ward 2 is a 20-bedded, mixed sex admission unit that delivers assessment and treatment for adults experiencing acute mental ill health predominantly from the Stirling and Clackmannanshire localities.

On the day of our visit, there were 19 people on the ward and one vacant bed. The ward also provides up to three weekly planned alcohol detoxification admissions in rotation with Ward 3, which is located nearby. In addition to this, Ward 2 facilitates the electroconvulsive therapy (ECT) provision provided in the theatres at Forth Valley Royal Hospital.

We last visited this service in April 2023 on an unannounced basis and made five recommendations. On the day of this visit, we wanted to follow up on the previous recommendations which included providing regular opportunities for individuals to discuss their progress, increasing meaningful structured activity and for care records and care planning to be outcome focussed, person-centred and regularly review. The response we received from the service was that awareness and monitoring would be increased, care planning audits would be completed weekly and activity programmes would be devised on a weekly basis and shared with individuals. Activities would also be offered over the weekend period.

Who we met with

Prior to the visit, we had a virtual meeting with the senior charge nurse (SCN). We heard that although there had been some improvement in staffing levels, this could still have an impact when other areas experienced high levels of clinical activity. Recruitment was ongoing for vacancies, including five band 5 registered nurses, one health care support worker and one part time activity coordinator.

Nursing recruitment and retention remains a national issue, however we are aware that due to the relatively easy commute to other health board areas, newly registered nurses in NHS Forth Valley have been attracted by alternative shift patterns, such as long days, that are available elsewhere. Following a staff survey, a six-month voluntary pilot of 12 half-hour shifts was commenced with the aim of finding a solution to this problem.

On the day of our visit, we met with, and reviewed the care of seven people, all whom we met in person and then reviewed six sets of care notes.

We also met with three relatives, the SCN, lead nurse for adult mental health, service manager and the clinical nurse manager. Additionally, we met with the new associate medical director and medical director.

Commission visitors

Denise McLellan, nursing officer

Tracey Ferguson, social work officer

Gordon McNelis, nursing officer

Jo Savege, social work officer

What people told us and what we found

Individuals receiving care and treatment on the ward provided mixed feedback. We were told that staff generally dealt with situations well however, some individuals indicated they had noticed a change in the experience levels of nursing staff compared to previous admissions. Comments included nursing staff being “approachable”, “nice and kind” but “inexperienced.” We were told of ongoing use of bank staff and that this was not ideal as individuals did not feel that they knew these nurses well enough.

Regarding their care and treatment, we were told that some people felt involved, offering positive feedback about the medical provision. One person told us that their doctor had been “excellent” in trialling different medication, always focussed on moving forward and that they felt “supported, reassured and listened to.” Of note, they told us that without this admission “I don’t think I would be alive otherwise.” Another person described being able to share their views about their care and support at the weekly multidisciplinary team (MDT) meeting, however, another found attending the meeting difficult and would prefer to see their consultant out with this on a one-to-one basis. Most people we spoke to had a lack of awareness about their care plans, telling us that they had not been given a copy to read. One person was aware of having a care plan but said they had “not seen it for ages” so were unclear on the content or any progress made. Overall, people told us that they felt respected.

Some people said they felt “bored” due to a lack of activities offered and where groups were facilitated, these were limited to a specific number of participants and this was compounded by any staff absence. One individual told us that there should be more to do on the ward as they spent most of their time watching TV and reading books and although they had been offered arts and crafts, they had no interest in this. The therapet visits were considered a positive activity by all.

Some people found the ward noisy at times and told us they liked to use the garden area to get a sense of space around them. This area was also being used by smokers, but we were told that this was an improvement, as people had been smoking on the ward and in toilets before. We noted that there was some litter including cigarette ends in the garden and were told there was no bin provided. We were unable to find one and raised this with the SCN who agreed to rectify this.

Most of the rooms had en-suite facilities however some people did have to share toilet and showering facilities, with one person informing us that occasionally they had to wait for access. There was also a concern raised about a lack of disposal facilities for a room; this issue was raised with the SCN, who offered assurance that this would be addressed immediately.

Opinions on the meals provided also varied with some people telling us that this was not good and that they preferred to purchase food from the shops in the hospital. One person said that apart from the fish and chips offered on Fridays, they tended to purchase takeaway meals or use the hospital canteen. Others told us that they particularly enjoyed the soup, and they found the meals generally “fine” with reasonable portion sizes. An individual told us that occasionally when they returned from passes off the ward, there were no meals available, but that nursing staff could usually find them a sandwich to eat.

Relatives told us that staff had been "really good", were "aware of everything" and kept them informed by regular updates and information, adding that they had been offered opportunities to speak with their relative's consultant psychiatrist. They spoke of their relief at the admission taking place and praised the staff who were delivering care and treatment to their relative. They appreciated the open visiting that could take place out with protected times. We were pleased to see posters displayed advertising the local carer's group, and that there was access to behaviour family therapy (BFT) for individuals and their families.

Care, treatment, support and participation

Case records

There were examples of comprehensive assessment that evidenced the participation of the individual, along with information from family with a good level of information gathered.

We found records of occupational therapy (OT) involvement that included detailed discussion for one individual whose discharge was delayed, due to a lack of availability of a suitable package of care. We noted the ongoing discussion with a plan of progression and read that this was discussed weekly at the MDT meetings.

Although we saw from the notes that one-to-one session with named nurses were being carried out, we found the frequency and recording to be inconsistent. Some people had an awareness of the named nurse system but described contact to be ad hoc as opposed to scheduled and frequent. One person described this as "two minutes in the corridor" if they happened to pass by, although we did find entries that were recorded following interactions, such as when an individual was out of the ward on an escorted basis.

There was evidence of risk assessments being reviewed and linked with care plan goals. An example of which was when consideration of intramuscular medication (IM) was being proposed following noncompliance and ongoing monitoring of mental health and risk.

Physical healthcare monitoring was detailed. The National Early Warning Score 2 (NEWS) tool was used to assess for risk of deterioration in relation to each individual's physical health, in addition to ongoing therapeutic monitoring of psychotropic medication.

Nursing care plans

Care plans provide a written record that describes the care, treatment and interventions that a person should receive to ensure that they get the right care at the right time. Care plans are a crucial part of supporting and helping the recovery process.

The service responded with detail on the improvements that were to be implemented following recommendations made on our last visit. Unfortunately, when speaking to people we were informed by some that they had not seen their care plans, nor had they been involved in developing them.

The sample of care plans we reviewed on the electronic recording system Care Partner were variable in quality and presentation, with some being more detailed than others. We were disappointed to find that whilst some were quite detailed, the process was not person-centred and appeared to be more system led. The way the system was designed resulted in a lot of historical information being provided; while there was a relevance and usefulness to this, it

was not time efficient. We found that a significant amount of information had to be read before reaching current updates which must present challenges for staff to who are required to access the most up-to-date information quickly, especially if they were unfamiliar with the system.

We saw a broad range of care plans, including physical health needs and monitoring, medication, activity and finances. In one care plan it was unclear who was managing the individual's finances as it documented that there was restricted access to their bank card. The care plan had recorded that finances were managed under interim powers but had not clarified what these were. This was discussed with SCN who advised that the service provider held appointeeship with monies being transferred to the hospital for safe keeping, which would also ensure the individual had access to funds. Advice was given that information should be recorded accurately in the care plan and in the MDT meeting record.

We found a care plan that had recorded the individual's agreement with their care plan, however this could not be evidenced as the signature box was blank. We raised this with senior managers who agreed that it would be possible to scan a signed document and upload this onto the electronic record. Another was detailed and comprehensive however appeared to be written about the person and where it asked whether the person consented to it, it was recorded as no, with no reason given to explain why.

We found evidence of care plans being reviewed however, there was acknowledgement that audits had to be carried out more frequently.

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

Recommendation 1:
Managers should ensure each individual's participation in care planning is evidenced in the care file and that they are offered a copy of these.

Recommendation 2:
Managers should ensure that all nurses are carrying out regular reviews of care plans that are meaningful and include effectiveness of interventions and reflect any changes in each individual's care needs.

Multidisciplinary team (MDT)

Ward 2 had two consultant psychiatrists with overall responsibility divided on a 75%/25% caseload basis. The reviews for the larger number were completed in two weekly MDT meetings with the remainder reviewed at a third weekly meeting.

There was regular involvement from OT, nursing, psychology and pharmacy who were located on the ward. Referrals could be made to other allied health professionals (AHPs) including physiotherapy, dietetics and speech and language therapy (SaLT). Meetings were recorded on Care Partner and individuals and families had the opportunity to participate, and where unable to do so, we were told that the consultant psychiatrist would provide an update by phone call. We were also informed that following the meeting, individuals met with their consultant

psychiatrist and a nurse. Community mental health services provided BFT to the ward. BFT is a practical skills-based intervention that promotes positive communication, problem solving skills and stress management with the family group. It delivers information and education to individuals and family members about mental health issues and treatment.

For the most part, we could see where individual's views and preferences were acknowledged and incorporated into the nursing summary of the meeting record, however in one record it was unclear whether the individual's views had been sought; there was also no evidence of whether the meeting discussion had been shared with them.

We saw from the MDT meeting record that the template used assisted in structuring the meeting, covering areas for review including legal status, diagnosis, medication and risk, with a separate summary of the review at the end of this document. There were examples of external partner involvement and discharge planning with a clear record of who attended, detailed discussion, actions, outcomes and who had responsibility for implementation. Additionally, we could see that the use of an administrator to take the notes helped to encourage undistracted participation from all disciplines attending.

Use of mental health and incapacity legislation

On the day of the visit, 12 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Most individuals understood their detained status and right of appeal however, one person was uncertain of their detained status. They could only recall very limited information about their admission and told us they did not have any paperwork available to them. We advised them that they should discuss this with staff and that they could also access independent advocacy in relation to their right of appeal. They did seem aware of this with further discussion and from our review of their care records, we were able to see that they had exercised their right to appeal their detention. Another person we met told us that they weren't sure of their detention status or rights, but did have independent advocacy support therefore, we suggested that they discuss this with them. One individual we spoke with had been admitted to the ward on a voluntary basis and was clear of their right to leave but was happy to remain.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Apart from one, all of the other consent to treatment certificates (T2) and certificates authorising treatment (T3) we reviewed were in place where required and corresponded to the medication being prescribed. We highlighted this and were told that this had been noted and a designated medical practitioner (DMP) visit had been requested.

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 in the records.

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 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 documentation in one record that someone had been made a specified person for the use of telephones however, we were unable to locate the relevant documentation. There were conflicting nursing entries in the care record in relation to whether the individual was specified or not which was confusing and lacked clarity of the person's status. We discussed this with the SCN who informed us that the individual was not.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

Recommendation 3:
Managers should consider MDT training in the application and use of specified person legislation to ensure that all staff have a clearer understanding of this legislation and ensure that all restrictions being placed on people are legally authorised.

When reviewing files, we looked for copies of advance statements. The term 'advance statement' refers to a written statement made under sections 274 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. We discussed advance statements, and one person told us that although they had not written one, they were aware that they could and told us they had an information leaflet in their room. We found copies of advance statements in the records for those who had made them.

Since our last visit, a new reception area had been designed immediately at the entrance to Wards 2 and 3. Ward 2 operated an open-door policy however, the door was locked with access by swipe card and ingress and egress monitored throughout the day on a rotational basis by clinical staff from both wards. We were told this system had been operational for approximately six months and enabled safer management of access. It was felt that using clinical staff was more efficient than having reception staff, as they were familiar with the individuals and their families, had ready access to prescribed time off the ward information and could gather other relevant information such as clothing descriptions before individuals left the ward environment or quickly identify other risks upon return.

We enquired about independent advocacy provision for individuals admitted to the ward on an informal basis. We were told that the advocacy service did not have the capacity to provide for this, however senior managers agreed to raise this at board level.

Activity and occupation

Activity coordinators facilitated a planned activity programme each week that included weekends, when nursing staff were allocated to facilitate groups in the coordinator's absence. Information was gathered at community meetings, and we were told that individuals then received a copy of the following week's available activities on a Friday afternoon.

Activities that were available included decider skills groups, anxiety management, therapet, cooking sessions, art therapy and gym sessions.

We saw a timetable displayed in the ward however, we heard that staff absence could impact on the frequency of the planned activities; we were told that often activities did not take place. We heard from those that we spoke with that they found there was a lack of structured activity

offered on the ward and that they could, at times, feel bored. We were made aware that there was ongoing recruitment for a part-time activity coordinator and that there was also staff absence due to a recent clinical incident. As the activity coordinator staff is relied on to schedule activities and during periods of staff absence, the level of activity offered was not replicated.

However, we did hear from one person that the level of activity offered was “so good”. They told us that their individual planner was full and included attending activities out with the ward and on the ward activities such as the “arts in mind” group and cooking sessions with the occupational therapist. We were able to see the completed planner in their room however, it had not been updated with the current date. Another individual told us of the input from OT and about the activities they enjoyed, which included listening to the radio, making cards and completing puzzles. Unfortunately, there was a lack of recording in the notes, so it was difficult to know what had been offered or declined.

Recommendation 4:
Managers should ensure that all activity participation is recorded, and the benefit of participation is evaluated.

The physical environment

The layout of the ward consists of single rooms, some of which have en-suite facilities. The rooms were clean with reasonable storage for personal effects appropriate to the setting, and individuals were able to personalise their rooms with art and photographs if they wished. Each room had a white board with information such as named nurse and mealtimes. There were a number of communal areas such as a quiet room, in addition to a lounge where people could socialise and watch TV. One individual used a wheelchair and told us that their en-suite room was adapted to their needs, with specific equipment in the shower area to enable staff to assist with personal care.

Wards 2 and 3 have some areas of shared space for therapy including a gym, OT kitchen and dining room. Mental health pharmacy was also located in this shared area which the team told us was helpful. Ligature reduction work was ongoing, with improvements agreed when funding is in place, which we were told was in progress.

There was a communal garden area that could be accessed between 08:00 and 22:30. It was a well-used space with some planted areas and seating and was enjoyed by individuals. We saw litter and cigarette ends and were told that there was no bin which we discussed with the SCN during the visit. One individual commented that because others used this area for smoking, they were reluctant to use it. This was disappointing to hear, especially since there is legislation in place to prevent smoking taking place within 15 metres of a hospital building. We raised this with managers at our end of visit meeting and were told that smoking was reintroduced during the Covid-19 pandemic lockdown however, they were actively exploring ways to reverse this.

Recommendation 5:
Managers should ensure the NHS Forth Valley ‘no smoking’ policy is explained to and complied with by all individuals in the ward, and that staff are given support to manage this.

Summary of recommendations

Recommendation 1:
Managers should ensure each individual's participation in care planning is evidenced in the care file and that they are offered a copy of these.

Recommendation 2:
Managers should ensure that all nurses are carrying out regular reviews of care plans that are meaningful and include effectiveness of interventions and reflect any changes in each individual's care needs.

Recommendation 3:
Managers should consider MDT training in the application and use of specified person legislation to ensure that all staff have a clearer understanding of this legislation and ensure that all restrictions being placed on people are legally authorised.

Recommendation 4:
Managers should ensure that all activity participation is recorded, and the benefit of participation is evaluated.

Recommendation 5:
Managers should ensure the NHS Forth Valley 'no smoking' policy is explained to and complied with by all individuals in the ward, and that staff are given support to manage this.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also 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. This has been added to the action plan.

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

Mental Welfare Commission 2024