Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 30 April 2024

Where we visited

Ward 3 is a 21-bedded mixed-sex admission unit providing assessment and treatment for adults experiencing acute mental ill health. Admissions for people aged between 18-65 years are taken mainly from the Falkirk area, however, occasionally there will be admissions from the Stirling and Clackmannanshire Health and Social Care Partnership (HSCP) area and out with this age range, where there has been consideration of individual need and risk. On the day of our visit, 19 people were receiving care and treatment.

The ward had provision for (up to) a three-weekly planned alcohol detoxification admission, and in conjunction with Ward 2 in Forth Valley Royal Hospital, co-facilitated electroconvulsive therapy (ECT) twice weekly.

There was a quieter annexe adjacent to the main ward area where admissions from child and adolescent mental health service (CAMHS) and maternal mental health could be cared for while awaiting specialist treatment.

We last visited this service in May 2023 on an announced visit and made five recommendations. On the day of this visit, we wanted to follow up on the previous recommendations which included ensuring care records were more personalised and outcome focussed, increasing opportunities for individuals to discuss their progress, an increase in awareness of rights for those admitted to the ward on an informal basis, an increase in meaningful structured activity across the seven days of the week and the provision of trained staff to facilitate increased access to the gym.

The response received from the service was that general presentation, activity, physical health and medication (GAPM) guidance would be sent to staff to increase knowledge about the level of detail required in the care records. This would be discussed in managerial supervision and staff meetings and monitored through transforming care at the bedside (TCAB) audits.

We were advised that one-to-one meetings between staff and individuals would be recorded in the care plan diary and when not completed as planned, these would be prioritised using a bring forward system. Consent from people admitted on an informal basis would be documented in the admission record.

Activities would be planned with individuals who would receive a copy of their weekly programme and participation in therapeutic activity documented. Physiotherapy would also deliver training to staff, allowing more flexible access to the gym, including weekend use.

Who we met with

Prior to the visit, we had a virtual meeting with the senior charge nurse (SCN) and clinical nurse manager (CNM). We heard that although there had not been any specific recruitment problems for this ward, there could still be an impact on staffing levels when other areas experienced high levels of clinical activity.

In response to the wider recruitment and retention issues in NHS Forth Valley, the ward was participating in a six-month voluntary pilot of 12.5 hour shifts. From the 27 staff complement, only three had opted to remain on the core (early, late and night) shift system.

We were told that although this pilot had only recently commenced, some benefits had already been realised in terms of time efficiencies made, such as reducing the number of daily handover periods between shifts from three to two. So far, this has resulted in 'freeing up' one hour daily which appeared to change the emphasis from prioritising handover related tasks, to focussing on other areas. It was hoped that hours saved in the longer term could be utilised for more care-related tasks.

On the day of our visit, we met eight people in person and then reviewed six of their care records. We also met with two relatives,

We spoke with nursing staff, the SCN, the activity coordinator, the charge nurse (CN) the CNM and the service manager (SM). We met with medical staff by video link at the end of the visit.

Commission visitors

Denise McLellan, nursing officer

Gordon McNelis, nursing officer

Jo Savege, social work officer

What people told us and what we found

When we met people, they spoke generally in positive terms about their admission to the ward. We were told by one person that the ward had a “friendly culture which has created a warm atmosphere” and that “people seem like they really care.”

We heard that relatives were kept informed and invited to weekly ward meetings.

One individual we met with was accompanied by their relative; they spoke positively on the transition from admission through to discharge planning, highlighting good links between the emergency department, the ward and community services. They told us that the experience they had was “very supportive, very responsive” and “staff are all amazing.” We heard the team described as having “really good knowledge and awareness of triggers, diagnosis, symptoms, good awareness of patients”, and they told us that they had felt informed, with thorough explanations given by medical staff. They knew what the discharge plan was, informing us how their return home would be supported.

Other comments included “everyone is kind, lovely and does their best”, that they were “friendly, there’s always staff to talk to.” However, one person reported occasional miscommunication between staff on different shifts which could cause confusion about changes to the plan of care following meetings but said this would eventually get resolved.

Another individual told us that they were happy with their treatment and that their room and general ward environment was clean with staff always available and approachable. “There is always someone to chat with”. They were aware of their plan of care following discharge and happy with the proposed follow up arrangements in the community.

Most people we spoke with told us that they felt involved in their treatment including attending meetings regularly and were familiar with their named nurse. However, one person said that they didn’t feel there was enough to do and that it was “boring” and although staff were generally okay, they felt some “wouldn’t go out their way for you.” Others described staff as “friendly and understanding, make time for you.”

The SCN was described as “fantastic” in addition to all the other staff on duty that day.

Opinions varied in relation to therapeutic activity available. We were told by some that there was a variety of activity offered and that staff “try to keep people busy” with encouragement to participate however, “not everything suits everyone.” Another person expressed their preference to be on their own and another individual told us that they found it difficult to keep themselves occupied, feeling that the activities offered were repetitive. They also told us that they wouldn’t choose to attend any of

the activities offered at the weekend, as these were offered on a one-to-one basis only and that they could only access the gym at weekends if the activity coordinator was available.

In general people were satisfied with their living space with individual rooms described as “a decent size” and could be personalised. One person raised an issue in relation to the underfloor heating. We were told it was not working properly and that their room was often cold. This had been reported to staff for repair and it was hoped this could be rectified soon. Another felt that the environment could be noisy at times and their sleep was disturbed by staff switching lights on during overnight checks. We were told the food portion sizes were “perfectly adequate” and breakfasts were particularly healthy, but options for vegetarians could be increased. One person said that they liked the food and that there was flexibility to eat their meals in their room if they chose to and they could get snacks on request. Another felt that the food “could improve”.

Care, treatment, support and participation

In addition to speaking with people, we were able to review a number of the care records. We found examples of participation, increased awareness from individuals about their care plans and there was clear evidence of family involvement throughout the admission to discharge process. People were familiar with the named nurse system, although one person told us that due to the shift system and periods of leave, they were unable to have as much contact as they would like, however, were aware that they could approach other staff during these times.

People told us that they felt involved, but one individual said that sometimes decisions were made that they were unaware of, despite their regular attendance at weekly meetings. We did hear from those that we spoke with that they felt they had a clear understanding of the treatment goals and involvement from the multidisciplinary team approach. Another person described being involved in their discharge planning and had information and understanding about this.

We found that the views of individuals were documented in the care records and there was consideration of spiritual care needs, physical health monitoring and treatment including contraception status, high dose antipsychotic monitoring and physical health reviews. There were also referrals made to other services, including the hospital addiction team, where appropriate.

Care records

Records of care were documented in the electronic information management system ‘Care Partner’. This system was used by all professionals involved in care and treatment delivery. The records reviewed were detailed and comprehensive, giving a sense of the person and a clear picture of their needs and goals from the admission. Risk updates and alerts were completed regularly using the multidisciplinary team

(MDT) approach. We also found records of one-to-one contacts in the continuous notes. One-to-one entries gave the reader a good level of detail about the individual and their circumstances.

Section 76 of the Mental Health Act requires the preparation of documented care plans for people who are subject to compulsory care and treatment. We found an example of a section 76 care plan detailing medical treatment and legislation. The goal of admission clarified interventions including engagement with occupational therapy (OT) and psychology to enhance functioning and insight. There was a detailed risk management plan.

Clinical notes provided evidence of participation and the benefits gained from activities, including descriptive entries by the art therapist. The individual's mood was clearly captured in the narrative. Most records were written in non-judgemental language, describing how people had found the activities provided to be delivered in a safe space, relaxing and a good escape. It also described how the people had been able to reflect on their progress with others in the group.

When reviewing one person's notes we found entries such as "visible at the onset" and "mood variable", "strange requests", "visible around the ward" and "bizarre in presentation" without giving context to a reader, or giving a clearer understanding of the person's presentation. We were told that some staff were new to their roles and improvement had been identified, with a working group underway to identify methods for this, including the CN carrying out regular audits on quality.

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.

On a recent visit to another ward, we highlighted the process of recording care plans on the Care Partner system 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 extracted, which although relevant and useful, was not time efficient. We found that a significant amount of information had to be read before reaching the most current update, which must present challenges for staff to access quickly, especially if unfamiliar with the system.

Despite this challenge, we found the content of the care plans to be good with evidence of collaboration although we noted in one record that they were written to/about the person. We found that one record had not been updated since admission to the ward two days previously. Both issues were discussed with the SCN who advised the aim is for care plans to be developed/reviewed within 48 hours

of admission and it had been diaried to be carried out that day. We were reassured that this would be actioned.

We were pleased to see that one of the individuals we spoke with had a copy of their care plan readily available in their room and that it had been signed by them.

Multidisciplinary team (MDT)
Ward 3 had three consultant psychiatrists and MDT meetings were carried out on a weekly basis. There was regular involvement from psychiatry, nursing, psychology and pharmacy, who were located close to the ward. Some mental health officers (MHOs) attended on a weekly basis and families were also invited. A mental health officer is a social worker who has specialist training in the law and working with people with mental ill health, a learning disability or a related condition.

We were told that OT attend where they have feedback to give. Referrals could be made to other allied health professionals (AHPs) including physiotherapy, dietetics and speech and language therapy (SALT), when required.

MDT meeting records were found on Care Partner with the MDT meeting template lending itself well to structuring the meeting. Use of the information coordinator to document the meeting discussion encouraged a wider participation from all professionals in attendance. Participation from individuals and relatives/carers was also captured and incorporated into the minutes. Discussions included admission information, legal status, diagnosis, risk status, medication and there was a separate summary at the end of the document. There was a record of actions and who was responsible for taking them forward, as well as noting attendees.

One MDT review incorrectly recorded the detention status and treatment authority an individual had in place. This was highlighted to the SCN during feedback who confirmed this would be corrected.

We were told that the clinical team met weekly with Woodlands community mental health team (CMHT) to discuss and plan future discharges and that there was strong links with social work.

Use of mental health and incapacity legislation

On the day of the visit, 11 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). We found that all mental health legislation paperwork was accessible and in order.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed, except for one,

where an antipsychotic medication had been added to a prescription however, this was not included on the T2 certificate or corresponding consent form. We highlighted this to managers and were told that this would be rectified.

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 the relevant information 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. Where specified person restrictions were in place under the Mental Health Act, we found relevant notification along with the corresponding reasoned opinion, however, were unable to locate the notification for one person and it transpired this had not been completed, but restrictions had been put in place.

Recommendation 1:
Managers should ensure that all restrictions being placed on people are legally authorised under specified person legislation.

Our specified persons good practice guidance is available on our website.

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 saw posters explaining advance statements on the notice board in the main day room. People did appear to have an awareness of them, and we were told that individuals were given 'opt-in' letters notifying them of their right to make an advance statement.

People we spoke with were informed of their rights, with awareness of their detention status and the appeal process. Some individuals had nominated a named person and had information about making an advance statement. For one individual admitted on an informal basis, although aware of the independent advocacy service, their understanding was this was only available for people subject to legislation. We saw posters advertising the independent advocacy service however, there was a view that there was only provision for people detained under the Mental Health Act. This was discussed with managers at a recent visit elsewhere in NHS Forth Valley and were told this would be explored further. Some people told us that they had used

advocacy services in the past and another had recently used them when appealing their Mental Health Act detention.

Since our last visit, a new reception area had been designed immediately at the entrance to Wards 2 and 3. The ward states it operates 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 were told that ward visiting was open from 08:00 to 20:00 daily, with no limits on visiting out with protected mealtimes. One person on continuous observation said that they were given some privacy during visits as the nurse supporting observations removed themselves to outside the room. Another person told us they were happy with the visiting arrangements and also with their prescribed time off of the ward. We were told by another person that the time limits to use time off of the ward were "fair."

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

Our previous visit highlighted a lack of therapeutic activity available. An action plan to address this included providing activities over the seven-day period. Activities were predominantly facilitated by two part-time activity coordinators over the seven days, complemented by nursing staff. Both coordinators provided a service to Wards 2 and 3. We were told that around one quarter of nursing staff had now accessed training from physiotherapy to facilitate safe gym sessions and that training was ongoing to maximise the number of facilitators and increase availability for this activity.

We heard mixed opinions on the level and variety of activity on offer. The weekly planner was placed on a notice board in the main corridor, and we were told that a flexible approach was adopted, which worked well. Activities were discussed at the Monday and Wednesday community meetings, with individualised plans devised following on from this. Activities offered included yoga for beginners, art group, relaxation, gym sessions, bingo, gardening, and a healthy eating group. Engagement and participation information was uploaded onto Care Partner. It was evident that

the coordinators were invested in their role. We were also told that they received regular supervision and support from the SCN from Ward 2.

The physical environment

The layout of the ward consisted of single bedrooms of which some had en-suite facilities. Individuals told us they were a good size with ample storage. From our walk around the ward, we saw that bedrooms were clean and brightly decorated and some had been personalised, with individual artwork and photographs.

Communal spaces were well utilised and there were several notice boards with helpful information about resources, including the Falkirk carers' group and Falkirk's Mental Health Association (FDAMH). There were also examples of positive affirmations displayed around the ward environment and corridors.

Ward 2 was located close by and both wards shared access to the gym, OT kitchen and dining room. Mental health pharmacy is located in this shared area, which the team told us was helpful. Anti-ligature work was ongoing with improvements agreed pending funding approval.

A garden area could be accessed between 07:00 and 21:00. This was a well utilised space however, we noticed a smoky smell in some areas and this was disappointing, especially since it is against the law for smoking to take place within 15 metres from 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 2:
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 that all restrictions being placed on people are legally authorised under specified person legislation.

Recommendation 2:
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