Mental Welfare Commission for Scotland

Report on announced visit to: Hope House, Bellsdyke Hospital, Bellsdyke Road, Larbert, FK5 4SF

Date of visit: 6 February 2020

Where we visited

Hope House, is a six-bedded low-secure female unit within the community of Bellsdyke Hospital. The Unit provides treatment, support and rehabilitation for women with more complex mental health care needs, who require greater levels of support and supervision. This facility opened in August 2017 with planned admissions of patients on a gradual basis, reaching full occupancy by October 2017. On the day that we visited all the patients had been in the unit since it opened.

Hope House also has access to on-site supported living flats and off-site independent flats for the purpose of assessment of independent living. Other wards on the Bellsdyke site have access to these flats. On the day of our visit Hope House did not have any patients in these flats.

We last visited this service on 31 January 2018 and made recommendations around the provision of GP services to the ward, development of a patient pathway between the ward and emergency services and the need for a protocol if a patient required further medical intervention following an incident of self-harm.

On the day of this visit we wanted to follow up on the previous recommendations and to meet with patients.

Who we met with

We met with and/or reviewed the care and treatment of five patients, and made contact with one relative following the visit.

We spoke with the clinical nurse manager, senior charge nurse, consultant psychiatrist, clinical psychologist and other nursing staff.

Commission visitors

Tracey Ferguson, Social Work Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Patients told us that they were receiving good care and felt they were getting all the support they needed. Patients told us that staff are approachable and always available and they felt involved in their care and treatment, participated in their care planning process and felt involved in their meetings to discuss their care and treatment.

Most patients that we spoke with were able to tell us where they were at in their journey of recovery. Some patients told us that they had been on continuous intervention for many years; however when they transferred to Hope House this reduced significantly until no longer required. Patients told us that the way in which the care, support, and treatment is delivered at Hope House has assisted with their recovery.

Care partner is the electronic system that the ward uses to store and record information about each patient. We saw patients care plans that were holistic and recovery-focussed. Interventions were detailed and evidence that each care plan was reviewed regularly with the patient. We saw detailed recordings of one-to-one meetings with nursing staff in the patients file as per care plan. Patient participation was recorded in the file and we saw a specific care plan that centred on patient rights. Some patients had signed their care plans and received a copy if they wished to.

We found detailed risk assessments along with risk management plans in place for each patient that were reviewed regularly. The risk assessment focused on the patients strengths and needs in a positive risk management framework, highlighting the patients coping strategies that they were learning and developing to either manage anxiety or self-harm. We were told that each patient was supplied with a self-harm box and can access this when needed. For patients who may require access to further medical intervention following an incident of self-harm we were told that a patient pathway and protocol has been developed between medical and emergency services and is working well and will continue to be reviewed.

We were told that all patients were registered with the local GP practice and they provided a direct service to the ward.

Given the complex needs of the patients, multidisciplinary team (MDT) meetings are held weekly and we were able to see from records that these meetings entail a lengthy discussion about each patient. Records were detailed, with clear actions and outcomes. The MDT consisted of a wide range of professionals involved in the patients care and treatment. The unit had access to psychology two days per week and had a full time occupational therapist.

We saw that patients care is also co-ordinated via Care Programme Approach (CPA) and we saw that CPA meetings were being held six-monthly. Minutes of these meetings were detailed, outlining progress of the patient journey. The minute recorded who attended these meetings, with clear actions and outcomes following the discussion. Some patients has signed the minute and where a patient disagreed this was also recorded on the minute.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Use of mental health and incapacity legislation

All patients were detained under the Mental Health (Care & Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995. For each patient's electronic file that we reviewed we saw up-to-date appropriate legal documentation.

Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required.

Where a patient's finances were being managed under Part 4 of the Adults with Incapacity (Scotland) Act 2000 we saw the required certificate was in place.

Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient 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. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

Two patients had been made specified persons and we found relevant legal documentation in place to authorise this, along with evidence of regular review.

Anyone who receives treatment under the Mental Health Act can choose someone to help protect their interests. That person is called a named person. Where patients wanted to nominate a named person we saw records of this in the patients file.

Patients had been supported to make an advance statement. An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. We saw copies in patients file where the patient had chosen to make an advance statement. Where a patient opted to not make an advance statement we saw recordings in the file where discussions had taken place and the record showed this

Rights and restrictions

We heard about a significant reduction in the levels of continuous intervention for individual patients since their admission to Hope House and how this has continued. Some patients shared their experience with us and told us how they saw this as a positive step in their recovery. During our visit one patient was on continuous intervention and we saw from reviewing the file that this was being reviewed regularly.

The wards ethos was to apply a proactive approach to positive risk-taking, which is assessed and evidenced as acceptable and in the patient's interests. We saw examples of this within the patients risk management plan. This approach was welcomed by the patients we spoke to.

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

Within Hope House there was a daily meeting, which patients were encouraged to attend, where staff and patients allocated tasks and discussed any activities or appointments planned for the day. In addition, there was a weekly community meeting to consider the overall activity, the ethos of the unit, celebrate success and consider any developments or future planning. There was a structured timetable displayed on the wall of the daily groups/activity that offered the patients social/educational and psychological input. These sessions were run by nursing, psychology and occupational therapy staff, and include mindfulness, safety and stabilisation, road to recovery and trauma informed sessions. We saw evidence of these activities in the patient files and the patients that we spoke with told us that there were lots of activities on offer. Patients told us how they are experiencing activities that they had never tried before and really enjoying these and learning new skills.

Where patients were having time off the ward as part of their care plan we saw that this was reviewed regularly and discussed at the MDT. Patients had access to community activities where appropriate and safe. These included Artlink, a community group who visit Hope House, gym attendance, both on site and with a women's group at a local facility.

Senior managers told us that there continues to be ongoing discussions about the addition of an activity coordinator to the staff team at Hope House.

The physical environment

The Unit was a bright, clean, spacious environment which was refurbished in 2017 to accommodate this new service. Each patient had their own bedroom space which they had personalised. On the day of our visit the unit was very quiet and calm. The living areas and activity areas were separate, and there was access to a secure garden space. The garden space had been developed with the patients since our last visit and there were seating and planting areas.

Within the unit there was a training kitchen and patients could use the facilities to make meals and work with the occupational therapist to develop new skills.

Good Practice

Hope House was the first pilot group in NHS Forth Valley to set up a decider skills group, where patients become skilled in using this model. Some of the patients were now skilled in applying

this model, such that this is being rolled out to other parts within NHS Forth Valley and some of the patients on the ward are part of this programme.

Any other comments

Prior to Hope House opening in 2017 the staff team were able to undertake the necessary training required to work with women who have complex needs and have experienced significant trauma in their lives. The challenge that the service now has is for new staff and the existing staff team to come together to learn and develop to enhance the service delivery to Hope House. Managers told us that the whole staff team cannot train together as the patients require a consistent and familiar team to support them on a daily basis. The team are currently looking at innovative ways to develop their knowledge, skills and experience.

Summary of recommendations

The Commission made no recommendations, therefore no response is required.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

MIKE DIAMOND
Executive Director (Social Work)

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 MWC 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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