Mental Welfare Commission for Scotland

Report on an unannounced visit to: Ward 2, Forth Valley Royal Hospital, Stirling Road, Larbert, FK5 4WR

Date of visit: 13 April 2023

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way that is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Ward 2 was a 20-bedded adult acute mental health assessment, providing care and treatment ward for males and females. The ward covered the catchment area of Stirling and Clackmannanshire in Forth Valley. On the day of the visit, there were five available beds.

We last visited Ward 2 on 29 March 2022 and made recommendations in relation to the Adults with Incapacity (Scotland) Act 2000 and meaningful activity. On the day of this visit, we wanted to follow up on the previous recommendations as well as look at the care and treatment provided on the ward.

Who we met with

We met with, and reviewed the care of five patients. We did not meet any relatives or carers on the day of this unannounced visit. We discussed with the senior charge nurse that we would be happy to make contact with any relatives or carers following the visit, if they wished. We spoke with the senior manager, clinical nurse manager (CNM), senior charge nurse (SCN), charge nurse, clinical director, staff nurses and a student nurse.

Commission visitors

Gillian Gibson, nursing officer

Kathleen Liddell, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

The majority of patients we met with were positive about staff in the ward describing them as “really nice” and “really person-centred”. However, all of the patients told us there were not enough staff and as a result, they were unable to spend much time with them. Patients described this as “frustrating”. Patients told us that they had a named nurse and one-to-one meetings with staff were offered, but not on a regular basis. The majority of patients told us they did not feel involved in their care and treatment. We were also told that patients felt staff lacked knowledge in regards to physical healthcare, and at times, they experienced delays in investigations and treatment.

We heard from staff that the ward team was supportive but due to staffing challenges, there was a sense of ‘compassion fatigue’. Low staffing numbers had an impact on patient care, as staff were often unable to spend the time that they wanted to with patients, particularly in relation to therapeutic engagement.

Staffing challenges were acknowledged by managers, who were actively trying to recruit and retain staff, but recognised this was an issue nationally. We heard that staffing levels in all of the mental health wards were assessed every morning and again throughout the day. However, Ward 2 staff were being regularly deployed to other wards to support safe staffing across the site. We heard that on occasion, the ward worked below safe staffing levels. There was regular use of bank staff to support safe practice on the ward.

Care records

Information on patients care and treatment was held on the electronic system ‘Care Partner’. We found this system relatively easy to navigate. It was clear to see where specific information was located, including mental health legislation. All staff involved in the patients care were able to input into this system that promoted continuity of care, communication and information sharing.

We found the information held in the daily care records was variable in quality. Some care records provided detailed and personalised information that included how the patient presented throughout the day, what they had accomplished and aspects of the day that had been difficult. Other care records did not record this level of personalised information and used language such as, as “visible on the ward” and “keeping a low profile”, making it difficult to determine current issues or interventions. We would have expected to see a consistent standard of record keeping that was person-centred and detailed personalised information.

We did find recording of one-to-one interactions between patients and nursing staff. These provided a high level of detail of the discussion that had taken place. However, we found the frequency of these to be sporadic and irregular, which was consistent with what patients told us.

We found the risk assessments to be comprehensive and of a good standard. The risks were clearly recorded with a plan to manage each identified risk.

Nursing staff continued to carry out 'Improving Observation in Practice' (IOP) safety checks. The ward had a clear visual system in place for staff to record their interactions with every patient every hour. A traffic light system was used to identify each individual's presentation that highlighted if further interaction or input was required. This information was readily available for all staff and was recorded in individual care records.

We were pleased to see comprehensive care recording from some members of the multi-disciplinary team (MDT), particularly from student nurses, psychologists and art therapists, which was personalised, and outcome-focussed.

Recommendation 1:
Managers should ensure that care records are personalised, goal and outcome focussed and provide more detail regarding how patients present throughout the day.

Recommendation 2:
Manager should ensure patients are regularly and consistently offered the opportunity to discuss their progress on the ward and any concerns they have in one-to-one meetings with nursing staff.

Nursing care plans

Nursing care plans are a tool, which identify detailed plans of nursing care, and effective care plans ensure there is consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

When we last visited the service, we found consistent, detailed, person-centred care plans that addressed a range of care needs for mental health, physical health and the more general health and wellbeing for each of the patients. We found reasonable evidence of patient participation in care plans or recorded reasons as to why they were not involved.

On this visit, we found the care plans in place to be variable. Some were detailed in relation to interventions required to meet identified goals, but some did not evidence strengths-based, goals or outcome-focused interventions. The language used in most of the care plans that we reviewed was not patient friendly and appeared to have been written to the person, as opposed to with them. One of the records we reviewed had no care plans in place. Evidence of patient participation and involvement was limited and patients told us they did not receive copies of their care plans. We were however pleased to see evidence of involvement with welfare proxies. The SCN informed us that she was aware of the variable standard of care plans in place at the time of our visit and had plans in place to address this by means of audit and staff development.

Since we last visited, the ward had started to use a care plan contact record to document care plan reviews, however we were unable to locate summative reviews in relation to progress towards goals and efficacy of interventions identified. When changes were made to a care plan, the care plan was rewritten, which made it difficult to establish what progress patients had made in working towards their care goals and any changes in their care needs.

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 3:
Managers should ensure nursing care plans are person centred, contain individualised information, reflect the care needs of each person and identify clear interventions and care goals.

Recommendation 4:
Managers should ensure care plan reviews are meaningful, include the effectiveness of interventions and reflect any changes in the individuals care needs.

Multidisciplinary team (MDT)

The ward had an MDT on site consisting of nursing staff, psychiatrists, occupational therapy (OT) staff, psychology staff, pharmacy and art therapy. Referrals were made to all other services, as and when required.

Each consultant psychiatrist held a weekly ward round in the ward. It was clear from the detailed and consistent MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and update on their views and involvement.

An MDT proforma was in use, which documented all those in attendance. We found these provided a detailed, holistic review with a good indication of each patient's presentation over the past week. We found detailed plans, outcomes and areas of focus recorded.

Patients and family/carers were invited to attend the ward rounds and were allocated a timeslot in advance. We heard patients were provided with a form to complete prior to the meeting to document anything they wished to raise or discuss. We saw good evidence of patient involvement, however, we heard from some patients that they felt a bit intimidated attending the meeting with so many professionals, and did not always feel adequately prepared. We heard that if they chose not to attend the meeting, their doctor would meet with them afterwards to provide feedback. We saw limited evidence of family/carer involvement.

We saw documented input from OT, psychology and pharmacy in the care records but found these slightly difficult to locate in the body of the records.

Use of mental health and incapacity legislation

On the day of our visit, 10 of the 15 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patients we met with during our visit had a good understanding of their detained status.

All documentation pertaining to the Mental Health Act including full findings and reasons following mental health tribunals, and was stored electronically on Care Partner and easily located.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. We reviewed all patients consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We found one instance where medication was

prescribed that was not authorised on a T3 certificate; we highlighted this on the day of our visit.

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 of this in the patient's file.

When we were reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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 and we were pleased to find some patients had advance statements in place on the day of our visit. We were also pleased to see posters displayed in the ward promoting advance statements. The Commission supports advance statements, as they are a way of ensuring that people with mental ill health are listened to and have their human rights respected.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We noted that one patient was identified as having a s47 certificate in place. On review of the certificate, we noted that it had expired. We raised this with the SCN on the day of the visit and requested an urgent review of the need for a s47 certificate for this patient.

When we lasted visited the ward, we made recommendations in relation to staff knowledge and understanding of the Adults with Incapacity (Scotland) Act 2000 and the need to ensure a clear process was in place to identify when there was a welfare proxy in place. We were pleased to hear that training had been added to the induction programme for new staff. We also heard that a face-to-face training session had been delivered to staff in the ward and they were required to complete an online training course as part of their mandatory learning.

We were also pleased to see where there was a welfare proxy (guardian or power of attorney), this was clearly recorded and there was a dedicated file in the electronic system that contained information regarding welfare proxies and powers in place.

Rights and restrictions

Ward 2 continued to operate an open door policy, however the door to the mental health unit requires swipe access. Patient access to and from this area continued to be monitored by a staff member seated at the door, noting who was coming and going from the ward, their expected time of return and what they were wearing at their time of leaving the ward. This role was shared by staff from Ward 2 and Ward 3 on a 30-minute rotational basis.

On our previous two visits, we were told that the creation of an alternative reception area had been planned, but work had been held up due to the Covid-19 pandemic. We were pleased to find this work had been completed on the day of our visit however, was not yet operational due a number of small security issues that were being addressed. In light of the staffing

difficulties in the wards, we were concerned to hear that staff from the wards would continue to monitor this area and discussed this on the day of our visit. We heard that consideration had been given to a receptionist post but this would require additional funding. We were also told that the knowledge and skills necessary to monitor patient's presentation on entering and leaving the ward required that of mental health staff.

The patients we spoke to on the day of our visit had a good understanding of their rights. Advocacy services were available on a referral basis and we were pleased that all of the patients we met with on the day were aware of advocacy support, if they wished to use it.

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 be applied. We found that where restrictions were in place, the appropriate documentation was available in the patient's record to authorise this.

We were told that prior to the Covid-19 pandemic, community meetings were held in the ward on a weekly basis. We were told that there were plans in place to recommence these meetings in the near future. This will provide patients with an opportunity communicate their views on any issues in the ward and discuss these with each other and staff. We look forward to hearing how this has progressed on our next visit.

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

On our last visit to the ward, we made a recommendation to managers to ensure there was a structured, scheduled, activity programme available to patients seven days per week to support meaningful activity. On the day of our visit were heard that the activity coordinator had recently retired. This post was advertised and provisions had been sought on an interim basis with a bank member of staff who was block-booked to specifically support activities on a part-time basis. We were told that nursing staff would facilitate activities on other days and weekends if staffing numbers allowed, which was often not the case.

We saw an activity timetable in place but were disappointed to see that this had not been updated for several months. Patients we spoke to told us they did not know what activities were on offer and often experienced feelings of boredom in the ward. They did however speak highly of the art group that was facilitated on a weekly basis by the art therapist.

We saw activities taking place on the day of our visit, but found limited evidence of this in patient notes. We were told the bank activity coordinator did not have access to care partner and this was being rectified.

We heard that some staff were trained in 'Decider Skills' but recent training had been cancelled due to staffing shortages.

There was an OT who covered several of the mental health wards and who provided assessment on focused activities. Patients also had access to a gym.

Recommendation 5:
Managers should ensure there is a structured, scheduled, meaningful activity programme available to patients seven days per week. Managers should also ensure activity participation is recorded and evaluated in individual care records.

The physical environment

The ward consisted of 20 single bedrooms, nine of which had en-suite facilities. Two of the rooms were designed for disabled access. There was a lounge area and a separate quiet area. On our last visit, the shared dining area was not being used due to Covid-19 restrictions. We were pleased to see this was in use again on the day of our visit.

The ward felt calm on the day of our visit. It was bright, spacious, clean and tastefully decorated. There were a number of rooms available for quiet space and visiting. We were pleased to see that patients were encouraged to personalise their bedrooms. Each bedroom also had a whiteboard, which detailed their consultant psychiatrist, named nurse and scheduled MDT time.

There was a laundry room available for patient use that was open at all times and an OT kitchen. We were disappointed that there were no provisions for patients to make themselves hot drinks or snacks throughout the day.

The ward had an enclosed garden that was large and well maintained. We heard that this was closed at 8pm and it was reported that this could lead to patients' vaping in the ward. We spoke to managers about this on the day of our visit and learned that there was no lighting in the garden, therefore it was closed early in winter months. We were assured this would be reviewed to support patient access to outside space.

We heard that prior to the Covid-19 pandemic the ward operated a smoke free environment. We heard that the restrictions imposed on patients led to a decision to allow smoking in the garden area. The service was considering how best to implement plans to reintroduce a smoke free environment and reduce the challenges. Whilst we were sympathetic to this situation, smoke free legislation is in place and applies to all hospitals and their grounds in NHS Scotland.

Summary of recommendations

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Recommendation 2:
Manager should ensure patients are regularly and consistently offered the opportunity to discuss their progress on the ward and any concerns they have in one-to-one meetings with nursing staff.

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Managers should ensure care plan reviews are meaningful, include the effectiveness of interventions and reflect any changes in the individuals care needs.

Recommendation 5:
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Good practice

Since our last visit, the ward has achieved 'Accreditation for Inpatient Mental Health Services' (AIMS). This is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Accreditation provides assurances of the quality of the service being provided. The accreditation process includes a self-review against the standards and a peer review to validate the results. The resulting report is presented to the Accreditation Committee before the accreditation decision recommended is ratified by the Royal College of Psychiatrists Special Committee on Professional Practice and Ethics (SCPPE). We heard from staff the positive impact this has had including better collaborative MDT working, enhanced patient experience and an increase in patient involvement and participation.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the 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.

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