



Mental Welfare Commission for Scotland

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

Date of visit: 27 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 which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Ward 4 provides assessment, care and treatment for older adults with dementia and admits both male and female patients. When we last visited the ward, the beds numbers had been reduced to 16 beds. Due to significant staffing difficulties experienced in the ward and across the wider mental health services in Forth Valley, on the day of our visit, the bed numbers had been temporarily reduced to 12 beds. There were no available beds but we were told that there was flexibility in the bed numbers if an emergency admission was required.

We last visited Ward 4 on 19 May 2022 and made one recommendation in relation to care plan reviews and evaluations.

On the day of this visit, we wanted to follow up on the previous recommendation as well as look at the care and treatment provided on the ward.

Who we met with

We reviewed the care of seven patients and met with two relatives. 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), clinical director and registered nurses.

Commission visitors

Gillian Gibson, nursing officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

Due to the progression of their illness, we were unable to have detailed conversations with patients, however, throughout the day we introduced ourselves and spoke to a number of patients. We observed the ward to be calm and patients appeared to be content and relaxed in the ward. They were happy to engage with us. We observed positive interactions between all staff and patients during our visit, including domestic staff and it was evident from these observations and discussions with staff that they were enthusiastic regarding their patients, and the care and treatment that they provided.

Relatives described the staff positively, stating they “couldn’t be any nicer”. We heard about the positive impact that the occupational therapy (OT) staff and activity co-ordinator had on patient wellbeing, however it was recognised that nursing staff were “busy and doing their best”. We heard that staff were “really good at answering questions or queries” but relatives had to seek staff out to initiate conversation and communication, as information was not routinely offered. Neither relative we spoke to were aware of who the named nurse was. As a result, they felt a bit lost and unsure in the ward, particularly on admission, due to being unfamiliar with ward policies and procedures. Examples of this included what they could or could not bring into the ward, where they were permitted to go in the ward and laundry provisions. One relative suggested a factsheet for relatives on admission would be helpful. We discussed this with the SCN on the day of our visit and heard that a factsheet had recently been created and was due to be implemented.

We heard that the patient group has changed recently with younger and more mobile patients presenting with higher levels of stress and distress. As a consequence of this, the average length of stay had increased. There were two registered nurses trained in stress and distress formulation. This is a bio-psychosocial approach, which supports staff to understand the potential causes of psychological distress. Psychology staff provided supervision. We heard that despite staffing difficulties, there was recognition of the need for dedicated protected time for formulation, which had been supported by ward managers.

We heard that a psychology assistant had recently been appointed and there was a plan in place for them to undertake work with relatives and carers to explore and discuss their expectations in relation to involvement in care decisions and communication. We look forward to see how this work has progressed on our next visit.

Ward 4 was experiencing significant staffing challenges, including registered nurse and charge nurse vacancies. We heard of the efforts of the service to actively recruit and retain staff, but recognised this is an issue nationally. We heard that staffing levels in all of the mental health wards were assessed every morning and again throughout the day. Staff from other wards were regularly deployed to Ward 4 to support safe staffing. The ward routinely used bank staff to ensure safe practice on the ward. We heard there had also been an increase in the use of agency staff, which although supported safe staffing, did not provide continuity of care. The service had explore block booking of agency staff to promote consistency and relationship building to enhance the quality of care provided.

Despite the significant staffing challenges faced by the ward, it was clear to see collaborative and cohesive MDT working and a good level of care and treatment provided to patients 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 pieces of information were located, including mental health legislation. All staff involved in the patients care were able to input information into this system, which promoted continuity of care, communication and information sharing.

We found the quality of information held in the daily care records to be of a variable standard. For the majority of entries, we were able to get a real sense of what was happening regarding physical health care, and of the treatment and support required with activities of daily living; we were unable to find many entries relating to an individual's mental health. We would have expected to see further narrative, particularly in relation to stress and distress. We would have expected that entries into the system would have detailed what was happening and how a patient was presenting before an episode of stress and distress, what interventions benefitted the individual and the outcome of non-pharmacological or pharmacological interventions.

Other care records used language such as, as "visible on the ward", "settled" 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.

Nursing care plans

Nursing care plans are a tool that identify detailed plans of nursing care, and effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. 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 of each of the patients. The language used was patient friendly and person-centred, which supported staff to really see the person as a unique individual. We saw evidence of a range of assessments that were used to inform care planning.

Each patient had an individualised stress and distress care plan created on the completion of a stress and distress symptom scale. These care plans were in paper format, as the electronic record keeping system did not support the layout required. The stress and distress care plans focused on unmet needs for patients, were person-centred and detailed.

We were unable to find any evidence of patient or carer involvement in any of the care planning. Where a patient was unable to be involved, due to their level of cognitive impairment, we would have expected to see care plans created and discussed with their relatives and carers.

When we last visited the service, we made a recommendation that care plan reviews and evaluations were clearly recorded in the nursing notes. We were told that 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 1:

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 a broad range of disciplines, either based there or accessible to them. This included nursing staff, psychiatrists, occupational therapy (OT) staff, psychology staff and pharmacy. Referrals were made to all other services when required.

There was a comprehensive MDT meeting template that was used to provide a record of clinical discussion and outcomes. Risk assessments linked to this template along with information about the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) status and Adults with Incapacity (Scotland) Act 2000. This acted as a prompt for review, provided a detailed record and a holistic overview of care and treatment. We found completed versions of the template in the records we reviewed. We were able to see who was in attendance at meetings and who was involved in care and treatment, progress that had been made each week, a summary of each patient's presentation and clearly defined goals and outcomes. We saw evidence that patients were reviewed regularly.

Relatives and carers were not routinely invited to attend MDTs. Instead, separate family meetings were held. The relatives we spoke to told us that there had been communication with the MDT regarding next steps in care, but there was an uncertainty about when meetings would take place. We also heard that there was no opportunity for relatives or carers to provide their views or input into MDT meetings. Relatives told us that there had not been any conversations with staff about information sharing and notification. We would expect to find the relatives and carers of patients with cognitive impairment working with the MDT, as partners in care, and their expert and unique contribution recognised.

Recommendation 2:

Managers should ensure that relatives and carers are involved in all aspects of care and treatment, including care planning and input to MDT meetings with clearly established and agreed lines of communication.

Use of mental health and incapacity legislation

On the day of our visit, 11 patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation pertaining to the Mental Health Act was stored electronically on 'Care Partner' and easily located. We found

documented recognition of the need for ongoing assessment of detention status to support least restrictive practice on the ward.

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' certificates authorising treatment (T3) under the Mental Health Act and found these all to be in order.

We were pleased to see that 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.

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 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. Section 47 certificates were in order and we were able to find the majority of corresponding treatment plans. However, we were unable to find evidence of discussion with relatives, carers or welfare proxies.

Covert medication is when medicines are administered in disguised form so that the person is not aware they are taking medication. The most common scenario in which this happens in practice is due to a patient's refusal to take medication when it is offered, and where treatment is deemed necessary for the individual's physical or mental health and where the person does not have the capacity to understand the consequences of not taking the prescribed medication. For those patients receiving covert medication, pathways were in place. We found these to be of varying quality in relation to review timeframes and involvement and inclusion of relatives and carers.

Rights and restrictions

Ward 4 continued to operate a locked door, commensurate with the level of risk identified in the patient group. There was a locked door policy displayed at the entrance to the ward.

We found robust, detailed risk assessments in place for each individual that were reviewed regularly.

We saw evidence of support and input from advocacy services, particularly for those subject to the Mental Health Act with representation at mental health tribunals.

Continuous Intervention is a process that ensures close monitoring of, and engagement with, someone who needs (for a period of time) intensive care and support. On the day of our visit, we reviewed the care and treatment of patients on continuous intervention. Care plans were in place and it was evident this level of intervention was being reviewed regularly by the MDT. Records detailed presentation on an hourly basis. We would like to have found more detail regarding the input and therapeutic engagement provided by staff throughout the day, as this was not fully reflected in the documentation, yet we observed this on the day of our visit. We fed this back to managers on the day.

The Commission has developed [Rights in Mind](https://www.mwcscot.org.uk/law-and-rights/rights-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

Ward 4 had an activity co-ordinator who worked between both older adult mental health wards. Activities were facilitated in group and on a one-to-one basis. We heard that rather than have an activity programme in place, activities were planned on the day to take into account each individual's presentation. The activity co-ordinator linked in with staff on a daily basis to explore who would most benefit from activity to help prevent and/or alleviate stress and distress.

The ward also had a dedicated OT and OT assistant who supported meaningful engagement. We were pleased to see activities offered, undertaken and clear benefits and outcomes documented in patient notes.

Pet therapy had been reintroduced since our last visit and we heard of the benefit this had for both staff and patients

The ward used the 'Getting to Know Me' booklet to explore individual likes and dislikes to support person-centred, meaningful engagement. We would like to have seen meaningful activities linked to, and included in, individual stress and distress care plans to support prevention of stress and distress and non-pharmacological interventions.

The physical environment

The layout of the ward consisted of 16 single rooms each with en-suite facilities. Each bedroom had a whiteboard that staff had used to promote orientation and detail person-centred information including life stories, likes, dislikes and 'what matters to me'.

The ward was bright, spacious, fresh and clean. There were murals on the walls as well as sensory stimulating wall mounts to occupy patients around the ward. On our last visit, there were seating areas in the corridors. We heard that furniture had been damaged and replacements had been ordered.

We were told windows in bedrooms were opened in the mornings and closed late afternoon. We were concerned that should a patient choose to spend time in their room throughout the day, it would be uncomfortable as we found the rooms to be very cold.

When we last visited, we were impressed by the proactive and creative thinking that had been put into a proposal to extend the ward to create a larger sitting room and for a sensory stimulation room. We were told these plans had been submitted for financial approval.

Patients had access to a courtyard that was accessible from several parts of the ward. It had good seating and use of space and was well maintained.

Summary of recommendations

Recommendation 1:

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

Recommendation 2:

Managers should ensure that relatives and carers are involved in all aspects of care and treatment, including care planning and input to MDT meetings with clearly established and agreed lines of communication.

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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