Mental Welfare Commission for Scotland

Report on announced visit to:

Forth Valley Royal Hospital, Ward 5, Stirling Road, Larbert, FK5 4WR

Date of visit: 31 October 2023

Where we visited

Ward 5 is a mental health ward which provided admission, assessment and treatment for male and female older adults with a functional illness or with an early diagnosis of dementia. Although originally established as a 20-bedded unit, capacity was increased by four beds during the pandemic. The four additional bedrooms (originally part of Ward 4) were used for isolating those with a potential Covid-19 infection. However, the ward has not reverted to the original number of beds. Each room had en-suite facilities. On the day of our visit there were no vacant beds.

We last visited Ward 5 in April 2022, and recommendations were made in relation to person-centred care planning, staff knowledge regarding the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) and the AWI Act documentation. We wanted to follow up on this up through discussion with individuals and staff and through reviewing the care records.

Who we met with

We met and reviewed the notes of six individuals on the electronic system 'Care Partner' and reviewed the notes of a further three individuals. We were unable to interview any relatives or carers during the visit, however we did have some contact with one relative prior to the visit.

Prior to visiting the ward, we had an online meeting with the service manager (SM), and deputy senior charge nurse (DSCN). On the day of the visit, we met the senior charge nurse (SCN), a Forth Valley independent advocacy representative, one of the consultant psychiatrists, and spoke with some of the other nursing staff.

Commission visitors

Denise McLellan, nursing officer

Lesley Paterson, senior manager (East team)

Anne Buchanan, nursing officer

Kathleen Taylor, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

We were pleased to hear that for most individuals their admission had been a positive experience and that staff had been very helpful and welcoming. One person told us that "they are always enquiring about my mental health and how I'm feeling". There was some uncertainty whether there had been an allocated keyworker, but overall, those that we spoke with said they felt comfortable and that they could approach any of the nursing staff if they needed anything. There was a recognition that the ward was regularly short staffed, and individuals voiced that this could be frustrating.

We also heard that the food was good and nutritious however, it lacked variety. One individual highlighted that on admission they were given non halal meat but said this was given due consideration thereafter. In relation to the bedrooms, these were reported as comfortable, and people said they felt safe on the ward.

Some highlighted a lack of activity on the ward with one person saying they had not been able to participate in ward activities, as they were waiting to be assessed by the occupational therapist (OT). This person had been given some puzzle books to complete but said they found the writing too small.

A relative raised concern about a lack of facilities, including televisions in individual bedrooms and felt the communication regarding the frequency of updates on how their relative was progressing was of a poor standard. We followed these concerns up with the service in advance of this visit and provided feedback to the relative.

Advocacy informed us of good links with the ward, and told us that the relationship with the multidisciplinary team was "very good". We were advised that although it was the social worker who would usually make referrals to this service, nursing staff could also do so. In addition to the referral system, advocacy also visited the ward twice weekly and phoned regularly, so this provided a 'catch-all' system.

The consultant highlighted good leadership in the team, identifying that the SCN took a keen interest. There was an acknowledgement of the staffing shortages across some disciplines. We were told this situation was not unique to Ward 5, and it was viewed as a good place to work, despite the staff shortages.

We spoke with one nurse who had requested a transfer from another clinical area and other nurses we spoke with were positive about the ward and leadership. Staff spoke about feeling supported but told us that they had been understaffed for months. We did hear that although staff can approach managers to discuss clinical matters, they have not had recent access to formal supervision, which they would have found very beneficial.

Recommendation 1:
Managers should provide regular managerial and clinical supervision to staff to give them an opportunity to reflect and discuss any issues or concerns they may have.

Nursing care plans

When we last visited, we recommended that the care plans should reflect patient involvement in their development, be more detailed and person-centred. Although some improvements had been made, we felt that a more detailed narrative would be helpful in the continuation notes, as the level of detail was variable.

There were some good descriptions of individuals' presentations however, this was not consistent. Having a greater level of detail in the continuation notes would have helped identify progress throughout the admission.

There were several completed assessments relating to physical and mental wellbeing with accompanying care plans, but it was difficult to determine if the individual had participated in these, or whether these care plans were reviewed and amended together as necessary. This would not be considered a person-centred approach, as although it identified risks and needs, it lacked evidence of a collaborative approach. The documentation would have benefitted from a subjective view from the individual as well as an objective view from staff. We discussed areas of improvement in relation to care plans and information that could improve the daily contact notes.

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 here:
https://www.mwcscot.org.uk/node/1203

Recommendation 2:
Managers should ensure individuals participate in the compilation of their care plans as far as possible, and this participation is evidenced in the care record.

Recommendation 3:
Managers should ensure regular audits of care plans to ensure quality and consistency in recording.

Multidisciplinary team (MDT)

The MDT consisted of nursing staff, three consultant psychiatrists, one part-time occupational therapist (OT) and two activity coordinators, shared with Ward 4. Physiotherapy was available and consisted of a physiotherapist and two physiotherapy assistants, again shared between the two wards, with a dedicated physiotherapy gym on site. There was pharmacy provision to the team following the retirement of the older adult consultant pharmacist and a replacement for this vacancy was being sought. Additionally, the psychology assistant delivered some sessions including a 'Decider Skills' group, managing stress and distress, and was also involved with discharge planning and risk assessment for the individuals in Ward 5.

We were told that although there was a shortage of registered nursing staff, there was a low level of attrition due to staff wishing to work in the unit. On occasion, agency staff were used but we were advised that sessions were block booked in advance, to enable familiarity with the ward and its routines. Agency staff must have experience of using, and have access to the Hospital Electronic Prescribing and Medicines Administration system (HEPMA). Managers

acknowledged that the whole-time equivalent staffing numbers were lower than they should have been and were looking to address this.

Care records

Medical reviews and weekly MDT meetings were recorded in the care records. It was relatively easy to access this documentation. Information included who attended the meetings but unfortunately, there was little evidence of patient participation. We were told that individuals were not routinely invited to weekly MDT meetings and that it would not be easy for them or their carers to attend with any regularity. We were told that individuals were consulted both prior to and following the meetings, with updates given to families by a phone call if there were any changes to the treatment plan arising from MDT discussion and decision-making process. However, this was not clear to see in the records.

We were unable to find examples of recent one-to-one discussions between individuals and staff. When speaking to the nursing staff they told us they would like to undertake more regular one-to-one contact with patients however, felt that they were only managing to do the fundamental tasks due to staffing shortages and pressure of work.

There was evidence of risk assessments being undertaken and documentation regarding discussion with patients about treatment plans and legal status. We reviewed copies of 'Do not attempt cardiopulmonary resuscitation' forms (DNACPR) and found that five out of the eight seen were in order however, three forms did not have the review box ticked to indicate whether a review was required. We were advised that this oversight would be remedied.

Use of mental health and incapacity legislation

On the day of our visit, seven patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Some of the patients we met with understood they were subject to detention under the Mental Health Act and documentation was in place in the electronic files and was up-to-date.

Part 16 of the Mental Health Act (sections 235-248) sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Three certificates authorising treatment (T3) under the Mental Health Act were in place where required. We noted that one had an error in relation to 'as required' medication and this was highlighted on the day. Section 76 of the Mental Health act requires the preparation of documented care plans for people who are subject to compulsory care and treatment. There are various points in the life of a compulsory treatment order (CTO) or compulsion order (CO) where there is a formal requirement for a care plan to be produced or amended. On reviewing a sample of records we saw evidence of detailed Section 76 care plans in the medical notes.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. Section 47 consent to treatment certificates were in order along with accompanying care plans apart from one.

There were several covert medication pathways in place and we noted that these had been completed using two different proformas. We discussed this with nursing staff and suggested they should use the form on appendix 1 of the Commission's good practice guidelines: https://www.mwcscot.org.uk/node/492

When someone is no longer able to make decisions about their own welfare, a court can appoint someone to make decisions for them. This person is known as a welfare guardian and can be a partner, family member, friend or social worker. Copies of welfare guardianship orders and power of attorney (PoA) certificates were available in the files. The whiteboard in the nursing office also provided details of a person's status under this legislation and we took the opportunity to discuss this with nursing staff. It was evident that knowledge around this had improved since our last visit, which was positive.

Rights and restrictions

Most individuals in the ward were admitted on an informal basis and there were none subject to specified persons restrictions on the day of our visit. One individual we spoke to was very clear on their understanding of being 'informal' and confirmed their rights had been explained and that they chose to remain. Another was unsure of their status and on checking the records we noted that they were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. They did not know the name of their social worker but were aware that they had one. They also knew that a package of care was being arranged before they could return home.

Ward 5 is an open ward however the door was monitored by nursing staff who sat nearby checking those who came into and left the ward as a way to reduce the risks of individuals leaving who were detained. The staff noted descriptions of clothing and whether an individual had the authorisation to leave the ward, as discussed at MDT meetings. There was a policy in relation to this and we suggested it was printed and displayed near the front door. There was a bell for patient/relative use for when the door was locked in accordance with this policy. We saw that patients had regular access to independent advocacy during their admission to the ward.

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

There was part time OT provision and two OT assistants shared between wards 4 and 5. We noted an activity board on the wall with activities such as 'therapet' and were told this was updated regularly. Our visit coincided with 'Halloween' and we were able to see staff and individuals participating and enjoying this celebration, with a party where dancing and singing were encouraged. We were told that the ward had invited 'Music in Hospitals' to this event and this was something that the ward could access twice yearly. We could also see that a great deal of effort and organisation had been made by staff to decorate the ward and provide snacks for this activity to benefit the individuals in the ward.

The physical environment

The ward layout consisted of one continual corridor in a horseshoe shape. It has single ensuite bedrooms, a small lounge, quiet room and separate dining area also formed around this pattern. The bedrooms were of a basic standard, but clean.

We noted that there were numerous ligature points in the bedrooms, including on the doors and in the bathrooms. We enquired *a*bout the programme of ligature work and were informed this continued to be regularly risk assessed and that there was ongoing discussion about improvements.

The internal garden was pleasant and accessible. It could perhaps have had more seating available given the occupancy level, however we did only see one patient using it. We were told there had been recent investment to purchase additional televisions for some of the rooms and that these were allocated dependent on an individual's assessed need. There was a lack of visitor and meeting rooms, so bedrooms were used for visiting.

Since the capacity in Ward 5 has increased, this appears to have had a detrimental impact on the availability of space. The communal areas of the ward were limited, and the dining room, lounge and quiet room were small in relation to the ward population. It was recognised by managers that there was a shortage of communal areas and they were looking at how areas could be repurposed.

Recommendation 4:
Managers should ensure a programme of work with identified timescales to address the environmental issues, including anti-ligature work and repurposing of communal areas.

Any other comments

The team had developed a very informative booklet together with individuals who had previously used this service. It contained detailed and helpful information in relation to ward orientation, information about what care plans were, safety information on prohibited items, visiting policies on searching of visitors and therapeutic activities available.

Additionally, there was a 'keeping well at home' booklet. When completed collaboratively with the individual, this document was a useful resource, comprising of three sections to include post discharge community arrangements, including medication information, a staying well plan and information in the event of an emergency. There was a patient feedback questionnaire attached to the back to help ascertain the helpfulness and ease of completion so that this resource could be amended or improved as necessary.

Summary of recommendations

Recommendation 1:
Managers should provide regular managerial and clinical supervision to staff to give them an opportunity to reflect and discuss any issues or concerns they may have.

Recommendation 2:
Managers should ensure individuals participate in the compilation of their care plans as far as possible, and this participation is evidenced in the care record.

Recommendation 3:
Managers should ensure regular audits of care plans to ensure quality and consistency in recording.

Recommendation 4:
Managers should ensure a programme of work with identified timescales to address the environmental issues, including anti-ligature work and repurposing of communal areas.

Service response to recommendations

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