Mental Welfare Commission for Scotland

Report on announced visit to: Tryst Park, Bellsdyke Hospital, Bellsdyke Road, Larbert, FK5 4SF

Date of visit: 15 February 2024

Where we visited

Tryst Park is a low secure male forensic service in NHS Forth Valley (NHS FV). It provides facilities for 12 individuals and is located on the Bellsdyke Hospital site in Larbert, Falkirk. On the day of the visit there were eight people in the ward, with another person housed in one of the off-site, self-contained flats owned by the hospital. There were three vacant beds.

When we last visited in September 2023, we made recommendations about training to improve staff knowledge and understanding of adults with incapacity legislation. We also highlighted the need for inclusion of individuals in relation to specified person legislation and a further recommendation around care planning. At this visit, we wanted to meet with individuals, follow up on previous recommendations, and look at ongoing care and treatment plans.

Who we met with

We met with four individuals and reviewed the care records of five people. Unfortunately, we were unable to speak to any carers or relatives.

We also met the senior charge nurse (SCN), clinical nurse manager (CNM), one activity coordinator, one of the psychiatrists, nursing staff, and the independent advocacy representative.

Commission visitors

Denise McLellan, nursing officer

Tracey Ferguson, social work officer

Kathleen Taylor, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

Individuals that we spoke with were positive in their views of their experience and were generally complimentary about the care given in the ward. Some highlighted that having consistent staff, whom they trusted and found to be approachable was a positive. One person described the nursing staff as “great” and told us that they had made “good progress”. We heard that they felt “involved” in their care, were happy on the ward, and met with their responsible medical officer (RMO) regularly. Another told us that they were very happy with their care, that staff were “friendly and approachable”, made them feel “welcome” which made them feel “safe”. This person commented that they did not wish to leave and “would be happy to end my days here”. We found this recorded in the chronological notes, and staff had acknowledged this individual’s reluctance to move on and were offering reassurance that they would be supported throughout the discharge planning process.

We were also told people felt supported, involved in their care, and able to speak about their plans. We heard about a range of activities offered both on-site and in the wider community.

We heard that recruitment and retention of nursing staff had been challenging however, this had improved more recently with the recruitment of five newly registered nursing staff. There was still a need to use bank staff, but block booking of bank staff helped to promote continuity and ensure individuals were familiar with the staff supporting them during each shift. We heard that retaining staff was difficult due to the geographical location and availability of posts elsewhere within commuting distance. In response to this, the service planned to pilot an alternative shift system of a 12.5 hour working day. It was hoped that the appeal of working the same number of hours over less days would be more attractive.

We observed respectful and cordial interactions between all individuals and the staff group. In addition, we saw people going out to community placements and having leave to go to their accommodation as part of their structured rehabilitation plan. One person was preparing to go out for the day with the activity co-ordinator for an activity tailored to his specific interest in history. We were able to speak to people who reported opportunities to have time out in the hospital grounds, as well as the wider community. We heard from some individuals who told us that they had regular access to on-site and off-site community groups, Activities included attendance at further education college courses, gym access, and activities offered via the occupational therapy staff. We found an activity programme displayed in the communal area, as well as individualised planners kept in bedrooms so they and could be easily referenced.

Nursing staff told us that they felt included in team decisions and one bank nurse informed us that they regularly requested shifts on this ward. The opinion given was that it was considered a safe and adequately staffed environment. The culture was also described in positive terms such as “a good team” with the “absence of cliques”. Newly registered staff told us they were placed on shift alongside more experienced staff and were encouraged to ask questions as part of their learning. We were told that supervision occurred regularly and that they also had mentors for the ‘Flying Start’ NHS national development programme for newly registered nurses. Regular drop-in sessions were also accessible for them as part of

the wider site training for specific areas of practice for example, venepuncture, improving observation in practice (IOP), and the shift co-ordinator role.

Care planning

We believe that care plans should ensure participation and support decision-making, and that nursing staff should be able to evidence how they have made efforts to do this. When we last visited the service, we found examples of detailed and person-centred care plans which addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. We were pleased to see that this had continued. We found most care plans to be well written, detailed, person-centred, and regularly reviewed. Interventions required to meet an identified goal were clear, however for one individual with epilepsy there was no care plan. This diagnosis was evident only from reading information captured elsewhere within the assessment and care programme approach (CPA) documentation. We brought this to the attention of the senior staff during feedback.

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.

Multidisciplinary team (MDT)

The ward had a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, and psychology staff. Referrals could be made to all other services as and when required.

We were pleased to note that the ward had a well-represented MDT with a broad range of disciplines either based there, or accessible to them, including psychiatry, nursing, occupational therapy, psychology, and other professions, as and when required.

Full MDT meetings occurred monthly, and individuals were invited to attend and become involved in decision making around care planning. It was clear from the very detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meeting and provide an update on their views. This also included the individual. There was no record of carer/family participation in the meeting, and we were told carers were not routinely invited to attend, either due to distance or lack of contact. We were told that two families met with the RMO, and senior charge nurse (SCN) every two months, that nursing staff were good at keeping relatives involved outwith meetings and that the team was in the process of updating relative information sheets.

In addition to the monthly MDT meeting, there were weekly situational, background, assessment, and recommendation (SBAR) meetings which captured things such as changes to care and treatment which did not require full team discussion. For new patients and for others where their clinical presentation necessitated it, MDT meetings would be held weekly for one month. The standard of recording was high, and it evidenced a consistent and comprehensive approach. We were able to see regular discussion about capacity and rights included in the documentation, as well as who attended each meeting.

We saw evidence of good practice where psychology worked in collaboration with occupational therapy (OT) and activity co-ordinators, to deliver activity provision, such as the

walking group. We were told that the psychologist was leaving, and an interim arrangement was being sought. The service was actively recruiting a psychologist but in the meantime the writing of the structured risk assessment document, HCR-20 (historical clinical and risk management-20) would be shared by medical staff. A psychology assistant would continue to provide low intensity psychological interventions.

Our previous report highlighted a reduction in general practitioner (GP) support since the Covid-19 pandemic with consultations primarily via phone contact. No improvement had been noted and GP phone advice continued to be provided by a local practice in Denny. There was no junior doctor available on site and if medical support was required, this had to be accessed from Forth Valley Royal Hospital, which was two miles away. We were told a proposal was being made for a core trainee medic to have responsibility for this.

Care records

Patient records were held on Care Partner, the electronic health record management system used by NHS Forth Valley. We found individuals' records relatively easy to navigate. Admission assessments were detailed, and we found copies of section 76 care plans on file. One-to-one sessions took place twice per week, one by a registered nurse and the other with a healthcare support worker (HCSW) or activity co-ordinator. Records showed a clear focus on mental and physical well-being with comprehensive physical healthcare monitoring in place. For individuals with comorbidity such as diabetes, we found this to be well monitored with regular glucose testing. There was documentation for physical healthcare, including the national early warning score (NEWS) tool and high dose monitoring for psychotropic medication. Recording of physical measurements was on a minimum weekly basis, unless otherwise indicated and discussed at SBAR meetings.

Risk assessments were in place and regularly reviewed. The functional analysis of care environments (FACE) tool was reviewed monthly at the MDT meeting unless there was a need for additional review out with this. The HCR-20, used in forensic settings to assess the risk of violence, was updated annually or biennially as mandated. We found these to be detailed and saw clear individual risk management plans included in the care records. In addition to this, there was evidence of multi-agency public protection arrangements (MAPPA) in place.

All individuals were subject to care programme approach (CPA), a multi-disciplinary care management process. This ensured that meetings took place consistently and recordings were of a high standard. There was evidence of individuals, relatives, and independent advocacy partners participating, as well as mental health officers (MHOs) attending. CPA meetings were held six monthly, and a copy of the minutes was held electronically. We were told that families and carers were invited to these meetings.

On this visit we were informed of one individual whose discharge from hospital was delayed due to awaiting a package of care tailored to their individual needs. Two others were out of area placements, meaning that their home health board was not Forth Vally. We were pleased to see that structured activity had been identified in their local areas as part of discharge planning. Discharge planning was arranged through the CPA process with regular updating of the suspension of detention plans (SUS) agreed via the MDT meetings. SBARs were

completed following each home leave to continually review the process in preparation for discharge. We found these reports to be very detailed.

Use of mental health and incapacity legislation

On the day of our visit, all individuals were detained under either the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) or the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act) as we would have expected in a low secure environment. Those we spoke with had good understanding of their legal status and rights. We found no issues regarding the required legal paperwork, which was readily available in the records. Individuals had access to independent advocacy support from Forth Valley Advocacy and legal representation.

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 found that consent to treatment certificates (T2) were accompanied by the relevant, signed consent forms. Certificates authorising treatment (T3) corresponded with prescribed psychotropic medication apart from one incidence and this was highlighted to the SCN who agreed to raise this with medical staff accordingly. T2 and T3 certificates were held on hard copy format as well as on Care Partner. We found this system most effective for ease of access, so that nurses can be reassured that they are giving medication in accordance with the appropriate legal authority at the time of administering it.

On our last visit, two of the recommendations related to the Adults with Incapacity (Scotland) 2000 Act (AWI Act), however, on this occasion there were no individuals subject to welfare power of attorney or welfare guardianship. We were told that training was made available and completed by staff via the TURAS e-learning platform. Two individuals were subject to Part four of the AWI Act in relation to welfare benefits. This meant that the NHS had applied to the department of work and pensions (DWP) for appointeeship to manage their welfare benefits. No concerns were raised to us by any persons visited whose funds were being managed by the hospital.

When we were reviewing the 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 are completed when a person has capacity to make decisions on their treatment. It sets out the care and treatment they would or would not like if they were to become ill again in the future. Health boards have a responsibility for promoting advance statements. We found no copies of advance statements on file but were told this was routinely discussed with individuals at the MDT meeting. We found evidence of this in one of the files where it was clear the individual had been made aware however, chose not to write one. Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests, that person is called a 'named person'. Where someone had nominated a named person, we found copies of this stored in the electronic file.

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 someone is made a specified person and where restrictions are introduced, it is important that the principles of least restriction and

participation are applied. The Commission is of the view that the need for specified person legislation for individuals in low secure forensic and intensive psychiatric care unit (IPCU) settings should be considered on a case-by-case basis, and not designated under a blanket approach. All individuals detained on the ward were designated as specified persons in relation to safety and security in hospitals. Although we saw reasoned opinions, we found that reasoning to be quite similar and the reason given for the specification was "due to ward policy." We looked at the NHS FV search policy and found this adequately covered searching, prohibited items and actions needed to maintain safety and security. We were concerned that some individuals may have been subject to an unwarranted additional level of restriction. This was disappointing given the same issue was identified on previous visits and did not appear to have been addressed. Therefore, we questioned whether designating all individuals was essential. Managers and psychiatry were clear that all individuals required to be individually designated as specified for the protection of everyone in the ward.

In relation to restricting telephone use, it was evident that this was individualised and outlined the risk in relation to telephones. We were given assurance that everyone's specification is reviewed on a three-monthly basis, in line with their individual management plans. There was a lack of clarity about whether one individual was specified for correspondence and the SCN agreed to discuss this with the RMO.

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

Forth Valley Advocacy provided independent advocacy to the ward and have delivered this resource for several years. We were able to meet with the representative on this visit and were told individuals were supported with regards to their rights whilst in the low secure setting.

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.

Recommendation 1:
Managers should ensure staff are cognisant with all aspects of specified person legislation, including the need for reasoned opinions to be individualised, set out a clear rationale for enacting these measures, and there is evidence of regular reviews.

Activity and occupation

Activities for people in the low secure wards are critical as they transition back to the community. In general, activities were based on personal choice and had a recovery focus. We heard from individuals that they enjoyed, looked forward to, and were content with the availability of choice of the activities. They spoke of opportunities both on and outwith the ward including a variety of groups such as horticulture, music, walking, arts and crafts, yoga, bingo, baking, karaoke, quizzes, healthy eating, cycling, and football. However, one person told us that occasionally there was a lack of staff to support the programme. The ward also had access to a pool table and board games. The walking group was physiotherapy led and was jointly available to the other three wards on site. The use of hospital transport helped to facilitate activities further afield, such as walking around the Kelpies attraction. Public transport was also encouraged where indicated.

Links had been established with further education establishments and employment projects. Individuals benefitted from attending college, work placements at the nearby canal project, selling teas and coffees, and in local charity shops. We saw photographs displayed in individual rooms of people participating in activities and excursions in the community.

Since our last visit, the ward now has two full time activity co-ordinators, shared across four wards. Provision was available over seven-days between the hours of 09:00 to 20:00, except for annual leave periods or training requirements. Individual timetables were populated weekly prior to the MDT meeting so they could be discussed, and suspension of detention approved. We viewed the general activity timetable in the main corridor as well as seeing individualised planners in bedrooms.

The physical environment

The unit was divided into three wings, two of which housed six bedrooms each. The third wing was a non-patient area, solely used for offices and a large meeting room.

Individuals did not have en-suite facilities and we were told that regular meetings looked at proposals for improvements as part of the overall site plans. Management was arranging an architect visit in relation to remodelling proposals. Separate meetings were ongoing for anti-ligature work in the toilet and showering facilities. We were told that funding for this was an issue and that it would be part of the longer-term plan. Phase one included the windows and blinds and improvements already achieved, which included raised room temperatures, as well as softening the look of rooms, making the environment more aesthetically pleasing overall.

Each wing had its own sitting room with a quiet room adjacent. One of the quiet rooms had a public phone for use by individuals from both wings. Both quiet rooms were small. There was also a shared dining area nearby with several cupboards for individuals to store food. The environment was clean, bright and tidy. There was a good amount of informative material displayed neatly on notice boards in public areas.

We found rooms to be personalised however, we were told of a lack of storage for belongings. One individual had numerous perishable foodstuffs on their windowsill which we discussed with senior staff. We were advised individuals could store this in the kitchen area and of plans to reconfigure rooms so that everyone has access to their own en-suite facilities. Although plans were in place, they had yet to be approved.

We were pleased to see that improvements had been made to the garden area and were told individuals could access this freely because it was enclosed by high mesh fencing. This gave the appearance of openness, and the garden was not overlooked by any other buildings. It also benefitted from a sports court and seating. We were told it was used frequently when weather permitted.

Any other comments

In addition to the comments made by individuals detained on the ward, we were informed from staff feedback that there was a healthy and supportive culture that was positive and inclusive. This was especially relevant given the number of newly registered nursing staff who

had recently joined the team. We also saw evidence of a cohesive and collaborative MDT. The addition of activity co-ordinators had been helpful, and we were told this had made a significant impact on improving opportunities for individuals.

Financial constraints had impacted on what the service could deliver in terms of the environment. Anti-ligature work and en-suite facilities in each room to maximise privacy and dignity, could be achieved if additional finances were available.

There was also a clear focus on learning and development, and this would ultimately improve the experience of those receiving care and treatment. It was also hoped that the flexible working pilot would be effective in addressing the recruitment and retention challenges.

Summary of recommendations

Recommendation 1:
Managers should ensure staff are cognisant with all aspects of specified person legislation, including the need for reasoned opinions to be individualised, set out a clear rationale for enacting these measures, and there is evidence of regular reviews.

Service response to recommendations

The Commission requires a response to this recommendation 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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