Mental Welfare Commission for Scotland

Report on unannounced visit to:

Loch View Hospital, Stirling Road, Larbert, Falkirk, FK5 4AE

Date of visit: 26 March 2024

Where we visited

Loch View (also called Lochview) is a mixed sex inpatient assessment unit, providing care and treatment for adults with a diagnosis of learning disability, autism and complex needs.

When last visited in December 2022, there were 18 beds however, there had been a temporary reduction of three beds since April 2023 to create a larger space to meet the complex needs of one of the residents. Individuals were accommodated across three houses, with the fourth house used as a multifunction area. There was one vacant bed on the day of our visit. Refurbishment of the unit to replace doors, paint rooms and replace furniture had commenced.

At our last visit we made recommendations on care planning, record keeping and the recording of participation/engagement in activities. We were informed that deputy charge nurses (DCN) had provided training to Band 5 staff nurses to improve the quality of the care plans, frequency of reviews and content of continuous notes. Improvements were also made to the recording of participation and level of engagement in activities. The senior charge nurse (SCN) had overall responsibility for auditing this. We planned to review the care plans to ensure that recommendations had been met.

Who we met with

We met five people and reviewed five care and treatment records. Additionally, we were able to observe one other who had was utilising one of the other houses temporarily during the day while refurbishment of their living space was underway. This individual was able to return to their own space in evenings.

Following our visit, we spoke to one relative and welfare guardian by telephone call.

We also met the SCN, clinical nurse manager, acting consultant psychiatrist and clinical director for the learning disability service.

Commission visitors

Denise McLellan, nursing officer

Tracey Ferguson, social work officer

Gordon McNelis, nursing officer

Andrew Jarvie, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

Overall, feedback received was positive. One person liked that they had been able to customise their bedroom to their own taste, however they told us that they became annoyed when others went into their room and staff had to intervene. They said that they enjoyed regular outings with the hospital and that they could be taken to the shops in half an hour of asking, as there were usually adequate staff numbers to facilitate this request. Another told us they were invited into meetings and chose not to but said no one came back afterwards to give feedback on the meeting's outcomes.

Although we were unable to meet with any relatives or carers on the day of our visit, one family did request that we contact them by phone. We had positive feedback, such as "on the whole I am very pleased. There has been some turmoil during the building works, but things are getting back to normal." They described the care and treatment their relative received as "excellent." They told us they had welfare guardian responsibilities and that they were always included in the meetings.

We were told about recruitment challenges for registered nurses and of proposals to address this. Bank and agency nurses were still used, however efforts were made to secure the same staff regularly, so they were familiar to individuals and with the ward environment. It was anticipated that by adopting a long day shift model, more staff from locations out with the immediate NHS Forth Valley area could be attracted. The nursing team was staffed by registered learning disability and mental health nurses; however, consideration was being given to some posts being opened to general adult nurses. Additionally, a visiting advanced nurse practitioner (ANP) and general practitioner (GP) provided physical health assessment and advice to the service.

An induction passport was being created and in-house, bespoke learning disability training would be delivered by allied health professionals, psychiatry and psychology. Topics covered would include positive behaviour support (PBS), trauma informed practice and safety and stabilisation. Formal recognition of this training was being considered.

We observed several whiteboards situated in the clinical areas. The 'my communication board' detailed useful strategies to interact with individuals in a meaningful and positive way. It gave detailed information to increase understanding. This was especially helpful for instances where unfamiliar staff were on duty. There was also a 'good day' board with pictures of activities enjoyed by individuals, such as outings and parties. We were told that some individuals looked at this at the beginning of the day and it was beneficial for providing them with a sense of wellbeing and comfort.

Care planning

Care plans provide a written record that describes the care, treatment and interventions that a person should receive to ensure that they get the right care at the right time. Care plans are a crucial part of supporting and helping the recovery process. Previous recommendations highlighted the need for more comprehensive care planning and reviews. On this occasion we found nursing care plans covering a broad range of needs. These were robust individualised,

and person-centred, giving the reader a clearer impression of identified needs with very detailed interventions and we could more easily see how these were linked to assessment and risk. They were thorough, with a clear understanding of an individual's presentation, triggers and strategies to support them.

We found evidence that changes had been made to the frequency of reviews and that these were now carried out monthly, with weekly audits. We were told that care planning was discussed in supervision. Other changes included the adding of summative evaluation at the bottom of the care plan for when it was completed, as well as guidelines for increasing the frequency of reviews.

Care records

A review of the electronic care records was undertaken. Information on patients care and treatment in NHS Forth Valley was stored on the electronic management system 'Care Partner', and we found this relatively easy to navigate. Assessments were noted to be comprehensive and holistic and there were detailed medical reviews, with recorded actions and planning. There was cognisance of peoples' strengths and needs and care was provided in correlation with risk assessment and management plans. Risk assessments using the functional analysis of care environments (FACE) document were available and we found that these had been updated regularly.

The standard of entries in continuation notes was high, with evidence that staff knew the patients well and observation of the ward showed caring attitudes and empathic care. We found the notes offered a detailed explanation of interventions and of individual's presentations. We were disappointed to note however, the use of wording such as "scowling and disgruntled" with no context to the situation. We raised this isolated case with managers who agreed to provide staff with further support and learning. Overall, the notes were very detailed with a clear focus on physical and mental wellbeing. Weekly one-to-one meetings were documented and tools such as talking mats, social stories, PBS and communication boards were used to increase understanding and help with transitions. There was a whole MDT approach in the formulation of daily management plans for consistency of care and we found examples of how planning events and making changes was matched to an individual's pace to reduce feelings of becoming overwhelmed.

Physical care needs continued to be addressed and followed up appropriately. We found evidence of ongoing interventions such as annual physical health monitoring, regular venepuncture, weekly dietetic involvement, podiatry involvement and use of tools such as the malnutrition universal screening tool (MUST) and 'hospital passport.'

Multidisciplinary team (MDT)

The unit had a dynamic MDT consisting of nursing, psychiatry, occupational therapy (OT), speech and language therapy (SALT), dietitian, psychology and a part time music therapist. The professionals were based either in the unit, or accessible to it and referrals could be made to other services.

MDT meetings were held weekly and were attended by welfare guardians, social workers and any other team members who were involved in an individual's care and transition. Details of

those attending was also documented. Meetings were structured and discussed care goals such as safe discharge, managing risk, seclusion, mental health and medication management.

There was also a strong focus on physical wellbeing with a dietitian involvement. We were pleased to see that the care programme approach (CPA) continued to be used and that carers and relatives engaged with this process. CPA is a framework used to plan and co-ordinate mental health or learning disability care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people, and by keeping the individual and their recovery at the centre.

Delayed discharges

We heard about delays in discharging individuals due to a lack of available individualised care and support packages. On the day of our visit, we were advised that there were 12 individuals whose discharge was delayed. For those from the Clackmannanshire and Falkirk areas, we were told that resources had been identified from social care providers with the appropriate skill set and the delay was due to recruitment challenges. This was predominantly the case for Falkirk; however, one individual was being considered for new build accommodation which would not be available until 2026. No placements had been identified for those from the Stirling area. We were made aware of positive relationships with the Health and Social Care Partnerships (HSCPs) for these patients and informed that the HSCPs actively try to secure accommodation and service provision to enable a safe and sustainable discharge from the ward to the community. We will continue to monitor the progress of these patients.

One person's situation was of particular concern. They were admitted to Loch View for assessment following the breakdown of the care home placement at the end of 2019. Their discharge had been delayed since November 2022 and the case was on the dynamic risk register. They were an out of area placement, but the responsible health board had refused a transfer back to their own specialist inpatient service. The local authority (LA) retained funding and care management responsibilities and were the appointed welfare guardian. However, the MDT had been advised by the LA that this case would not be considered until 2025, as priority was being given to inpatients already in that service. The Commission believed this person had been disadvantaged by this decision. The local area practitioner wrote to the Chief Social Work Officer following the visit and is awaiting a response. The MDT continued to be frustrated around the lack of discharge planning and this was made a recorded matter at the Mental Health Tribunal for Scotland hearing (MHTS) in February 2024.

Carer involvement

Part 4 of the Carers (Scotland) Act 2016 (Carer's Act) decrees that health boards and local authorities have a duty to involve family/carers in carer services and the hospital discharge of cared for persons. They must involve families and take account of their views and wishes. We were pleased to hear that most carers attended MDT meetings, to which they were all invited and that they were very much involved in visiting their family member regularly.

We were also told that although there was not a specific carer group in Loch View, carers were signposted to the carers' centre. We were pleased to see a suggestion box available, to seek views on what people thought about the service.

Use of mental health and incapacity legislation

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (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. On the day of our visit, 11 patients were detained under the Mental Health Act. We reviewed all certificates authorising treatment and found these to be in order, except for one. We were told that a designated medical practitioner (DMP) visit had been arranged for the second opinion. Where medication was administered covertly, we found evidence of good practice in that the covert pathway in use was regularly reviewed and discontinued, as needed, following discussion at MDT meetings.

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 a Section 76 care plan in the medical notes that was detailed and had outcomes for future planning.

When someone is unable to make decisions about their own welfare, a court can appoint someone to make decisions for them under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). 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 certificates were available. For one individual it was documented that the local authority held both welfare and financial powers however, they only held welfare authority.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the AWI Act must be provided. 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 consent to treatment certificates were in place, with accompanying personalised treatment plans.

Rights and restrictions

Due to the complex needs of people in Loch View, the unit operated a locked door policy, and we were satisfied that this restriction was commensurate with the needs of the group.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is made a specified person in relation to this, and where restrictions are introduced, it is important that the principle of least restriction is applied. Restrictions for one individual were recorded and the appropriate documentation was available in the files to authorise this, including evidence of a reasoned opinion.

When we are reviewing files, we look for copies of advance statements. The term ‘advance statement’ refers to written statements made under sections 247 and s276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they do or do not want. Health boards have a responsibility for 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. We did not find any in the selection of files reviewed but were told that they were promoted at the point of admission and revisited at MDT meetings.

We were informed of adaptations made to rooms to safely manage individuals with complex needs who present with behaviours that challenge. Some areas were described as 'suites', where four rooms were allocated for the sole use of some individuals in the unit. One room was used as an en-suite bedroom, another for activities with access to sensory items and the third used as the space for safe engagement with staff for agreed periods of two to three minutes at a time. The fourth room was used for storage. There was also open access to their designated garden area.

We reviewed the care and treatment relating to a situation where long-term seclusion had been in place since 2020. We were concerned to see that there was no seclusion policy in place but were told that the MDT had sought advice from the Commission and subsequently linked in with other services for examples to guide this practice. We were told that the service was in the process of writing a seclusion policy and we reiterated the importance of this.

A long-term plan had been agreed by the MDT, which covered identified needs, aims and interventions. Although there was good rationale for seclusion being used, it was difficult to see from the notes when improvements occurred as there was a lack of detail in the care plan and risk assessment reviews. We suggested that this should be recorded in the MDT and CPA meetings. There were also some gaps where face-to-face contact occurred in relation to what had been recorded on the activity planner.

The Commission has produced guidance on the use of seclusion. We recommend that wards which impose restrictions on an individual's freedom of movement develop a policy on use of seclusion with reference to our guidance.

Recommendation 1:
Managers should ensure a seclusion policy is finalised, taking into account the physical and emotional wellbeing of the individual and to provide the necessary guidance for staff.

Where the use of CCTV was in place, the camera images could be viewed in the nursing office, and this raised questions about privacy and dignity, as they could be easily observed by non-clinical staff. This information was not included in otherwise very detailed plans.

We discussed this with the SCN who informed us that there was a switch on the screen that could turn off the images when necessary. We suggested that situations where this should be adopted should be made explicit to all staff and be incorporated into a specific care plan.

We were told that there was an independent advocacy referral pathway, and this was always discussed at the point of admission to support individuals requiring this service. We noted that for some individuals, they did not have advocacy involvement and the expression of their views was limited at meetings. We were told this resource was difficult to access and advised that the SCN liaise with the mental health officer (MHO) from the LA to ensure that individuals could access this service so that their views could be represented.

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.

Activity and occupation

Engagement in meaningful activity is essential to an individual's health and wellbeing. We would expect to see a person-centred activity programme that is based on a multi-disciplinary assessment of an individual's needs and strengths.

Following our last visit, changes were made to the recording of participation and engagement in activity. The calendar function on 'care partner' was populated by nursing staff on Sunday nights for the week ahead. As well as structuring the week ahead with details of planned OT sessions, family and professional visits, OTs updated this record daily with information, capturing whether activities were participated in or declined, including information on levels of engagement. This calendar function allowed a good overview of a person's week and was complemented by the daily nursing notes detailing what went well and what didn't go so well, providing a more informed picture.

The occupational therapy resource was based in the multifunction area and led by a Band 7 OT, with two occupational therapy technicians. During our visit, we were able to see a variety of therapeutic and recreational activity offered. As well as viewing the art and music therapy rooms, we saw individuals also had use of a living skills room for maintaining and improving existing skills. We were given access to the 'snoezelen room'. This was a controlled multisensory environment providing therapy for people with autism and other developmental disabilities.

When reviewing the records, we found a good example of activity tailored to one individual's likes and preferences. Amongst some interests we noted drawing, sensory activities, watching television and foot massages. Music therapy was involved, and the person got enjoyment from playing ukelele. Exercises, such as walking in the garden, using the ward bikes and even playing football in the corridor of their suite of rooms was recorded.

The physical environment

The accommodation was split into three houses with the fourth being utilised for clozapine clinics, MDT meetings and a staff wellbeing area. It was a clean, bright environment and had a pleasant ambience. The artwork on display, created by the individuals in the unit, gave a welcoming, inclusive feel. Lounge and dining room facilities were clean and well maintained. These areas were peaceful and adaptable.

The inner central space between the buildings contained a specifically designed outdoor gym that had been developed to support sensory needs in addition to providing space for physical activity. There were raised beds to allow patients and staff to grow vegetables and flowers. The outer circumference of the unit was surrounded by large gardens, enclosed by a double sided eight-foot fence. These areas were well maintained and used regularly. We discussed how the site had been encroached on by the proximity of a housing development and were

told that one-way mirrored windows had been installed to maximise the privacy and dignity of the unit's residents.

It was positive to see that bedrooms had been personalised and there was no outstanding work required in relation to anti-ligature work. We were told that this continued to be reviewed quarterly. The programme of works being carried out necessitated some disruption to living space, but this appeared to be managed in a careful and considerate way.

Any other comments

Overall people told us that they were generally happy with the care they received and found staff supportive. It was evident that the clinical team responded to the needs of people holistically using a person-centred approach. We were pleased to hear of four weekly supervision sessions provided to the nursing group. We were told this was undertaken by a three-month rolling pattern of one individual session by either DSCN or SCN and the other two supervisions in a group setting.

The team was in the process of working towards Royal College of Psychiatrist accreditation and we wish them well in this endeavour.

Summary of recommendations

Recommendation 1:
Managers should ensure a seclusion policy is finalised, taking into account the physical and emotional wellbeing of the individual and to provide the necessary guidance for staff.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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