Mental Welfare Commission for Scotland

Report on announced visit to: Bellsdyke Hospital, Trystview, Kinnaird Village Centre, McIntyre Avenue, Larbert FK5 4SF

Date of visit: 16 July 2024

Where we visited

Trystview is a mixed-sex, slow-stream mental health rehabilitation ward, based on the site of Bellsdyke Hospital. Although there are 20 beds on the unit, some changes to the ward have been made since our last visit, such as bedrooms being repurposed for meeting rooms.

On the day of our visit there were 12 patients in total, three of whom were boarding from the two adult acute mental health admission wards at Forth Valley Royal Hospital (FVRH). We were told this was due to capacity issues experienced at FVRH.

We last visited the service in October 2022 on an announced basis and made recommendations about care planning, door locking practices, specified person legislation awareness and documentation, and ligature risk.

The response we received from the service included education on the writing of care plans to include more person-centred wording, the use of language, increased participation of the individual and regular reviews and audit processes. We were pleased to learn that the door locking practice had ceased with immediate effect following our last visit. Awareness of specified person legislation was promoted and incorporated into the structured template for the multi-disciplinary team (MDT) meeting, to ensure ongoing regular review. Finally, in conjunction with other wards, a programme of works was ongoing to address ligature risk across the wider Forth Valley mental health inpatient estate.

Who we met with

On the day of the visit, we met with two individuals and reviewed the care and treatment of six people in total. We also had the opportunity to speak with two relatives who had requested to meet with us.

Prior to our visit, we had a virtual meeting with the senior charge nurse (SCN) and clinical nurse manager (CNM). Further to this, we also met the service manager (SM), psychiatry, psychology and other members of the leadership team, including the chief nurse and associate medical director at the end of the day meeting.

Commission visitors

Denise McLellan, nursing officer

Juliet Brock, medical officer

Paul MacQuire, nursing officer

What people told us and what we found

One person met us immediately on their return to the ward from a swimming activity and told us that they found this to be both enjoyable and beneficial. They informed us that they had very recently transferred to Trystview from one of the admission wards and were aware of the goals of this admission. They expressed their preference for this ward's routine explaining that it was "quieter and less busy." They spoke positively about the level of activity available and their engagement with this. They described everyone as "friendly" and the staff as "really helpful and always taking time to listen." In terms of food quantity and variety this was described as "fine." They did not have any specific concerns about their care or treatment or transfer of ward and said that overall, they were happier.

We also had opportunities to speak with relatives who had requested to meet us. One expressed dissatisfaction with their relative's treatment plan and their view that the illness had progressed despite various treatment with no apparent improvement. They told us that they planned to formalise a complaint in relation to this. They appeared to understand rights and to have an awareness of the formal complaint's procedure. Staff were aware of these concerns and there was ongoing discussion in relation to this.

Another relative highlighted that although happy with the nursing care, they felt the overall treatment plan was not addressing their relative's mental illness and symptoms sufficiently, and that an alternative treatment plan should be considered. They also raised their concern that sometimes communication was variable, despite their role as named person and their active participation and attendance at MDT and care programme approach (CPA) meetings. They were satisfied with the variety of activity offered and confirmed that there was sufficient information to access independent advocacy and legal advice. Again, staff were aware of this, and we were told that they continued to listen and offer support.

As well as speaking to individuals, we met with nursing staff. We were informed of improvements in staffing levels and that the two Band 5 registered mental health nurse vacancies had been recruited to, with newly qualified staff due to take up post in September 2024. Following successful recruitment, there would be one remaining vacancy for a Band 3 clinical support worker (CSW). Funding had also been approved for an additional Band 6 deputy charge nurse (DCN); however, the substantive DCN was on secondment to another ward on site at this time.

We were also told about refinements made to the care planning process, including the continuation of audits, to ensure a higher standard was achieved and maintained. Individuals were encouraged to participate in the development of the care plans and an improvement in standards was continually sought.

Care, treatment, support and participation

Care records

A review of the electronic care records was undertaken. Information on care and treatment in NHS Forth Valley was stored on the electronic management system 'Care Partner'. We found this relatively easy to navigate and were able to access several key documents during our visit. Assessments were noted to be comprehensive and holistic and there were detailed medical reviews, with recorded actions and plans to accompany these.

Records reviewed were comprehensive, giving a sense of the person and a clear picture of their needs and goals. We found positive examples of MDT working throughout the records in CPA and MDT meeting minutes, risk assessments and management plans which were completed timeously, with other documentation cross referenced to this.

Risk assessments were completed using the functional analysis of care environments (FACE) document. Each initial Care Partner record highlighted numerous alerts corresponding to ongoing risks.

There was also a recording system to monitor exit and entry of individuals to the ward. This consisted of a staff member making a written record of clothing descriptions, checking the agreed time off the ward plans, along with providing an opportunity to note peoples' overall presentation. We were assured that this was a safety measure as opposed to an action that would unnecessarily limit or restrict freedom of movement.

The standard tools to monitor physical health screening were available and completed in accordance with individual monitoring requirements. We found records supporting physical health monitoring in conjunction with referrals to specialist services. The ward continued to have input from a local community general practitioner (GP) and health promotion was encouraged, as evidenced in smoking cessation discussions which were also documented in the records.

There were clearly documented one- to-one discussions between individuals and staff, and we noted that everyone had a named nurse, associate nurse and a named CSW assigned to them, identifying who would be available across the shift pattern, with the aim of encouraging the development of positive therapeutic relationships. We saw there had been regular contact with these key staff documented in the patient contact record. There was also a focus for providing a diverse range of activity and occupation, with good levels of activity offered and participation documented.

Nursing 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. They are a crucial part of supporting and helping the recovery process. When we last visited, we found them to be “prescriptive and instructive with a focus on diagnosis”. We were pleased to now read care plans that were holistic and person-centred, written in the second person and using more positive and respectful language. We saw that some had been agreed then printed off to allow the individual to sign them. The completed document was then uploaded onto Care Partner. One care plan had not been signed, however, it appeared to show collaboration from the way it was written, with evidence of discussion and feedback about this individual’s concerns documented. There were numerous care plans regarding physical and mental health needs, CPA status, risk behaviour and vulnerabilities and medication concordance.

Although there was evidence of regular reviews, it was sometimes unclear what the specific progress or change had been in the interim period. We discussed this with the SCN, and they acknowledged this is an area where improvement was continually sought.

Multidisciplinary team (MDT)
The unit had an MDT consisting of nursing staff, psychiatry, occupational therapy (OT) and psychology. Referrals could be made to all other services, such as speech and language therapy and dietetics, as and when required.

Two consultant psychiatrists shared responsibility for the ward. MDT meetings occurred fortnightly; however, both visited the ward weekly for reviews out with the meetings. Weekly reviews were also carried out by the respective consultant psychiatrists for the individuals boarding from other wards.

We were informed that individuals and families (where there was contact with relatives), were invited to attend MDT meetings. However, it was noted that most families preferred to limit their attendance to CPA meetings due to their own work commitments. CPA is a framework with a particular focus on planning the provision of care and treatment, with the involvement of a range of different people and by keeping the individual and their recovery at the centre. Outwith meetings attended by relatives, nursing staff were responsible for providing feedback via telephone about any changes made to care and treatment.

We found the MDT meeting template a helpful tool to structure the meeting, and the MDT records were comprehensive. The template covered areas that prompted review; these included legal status, specified person status, diagnosis, prescribed medication, medication authority, and risk, with a separate summary of the review at the end of this document. There was a clear record of who attended with examples of external partner involvement, such as recent mental health officer (MHO) input. There were detailed discussions, required actions, outcomes and who the key personnel that were responsible for the implementation of any actions.

Use of mental health and incapacity legislation

On the day of our visit, 11 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Documentation relating to the Mental Health Act was accessible and in order.

Part 16 sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Forms authorising treatment (T3) and consent to treatment certificates (T2) were in place where required and corresponded to the medication being prescribed. These certificates were available in hard copy in addition to being accessible on care partner. One person was still within the two-month period where authorisation was not legally required and the SCN confirmed they would follow up whether a second opinion doctor had been requested to ensure that medication was authorised correctly when necessary.

There was discussion between the Commission medical officer and the responsible medical officer (RMO) on another prescription matter following the visit.

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 s76 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 Adults with Incapacity (Scotland) Act 2000 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We saw a s47 certificate in one of the files reviewed and it had an accompanying treatment plan in place. We were told of other individuals where the guardianship process was being progressed. In the files we reviewed, the documentation was informative and clear, using the correct terminology and included details of proxy decision makers and the stage of the process outlined for reference.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found details of this in the patient's record.

Rights and restrictions

Trystview operated an open-door policy, and we were pleased to see that there were no restrictions to this, and that the policy was displayed.

From reviewing records, we were able to determine that individuals had access to independent advocacy, and some had used this service previously for the purpose of appealing their detention. Another told us that they had accessed advocacy in the past and had exercised their right to appeal their detention, however, were unaware of whether they had nominated a named person. We discussed this with staff who agreed to follow this up.

When we are reviewing patient files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 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 the use of advance statements, as they are a way of ensuring that people with mental ill health are listened to and have their human rights respected. Copies of advance statements were available in the records where these had been completed.

The RMO subsequently, informed us that NHS Forth Valley had devised a system with local Mental Health Act administrators to ensure that each patient detained under compulsory treatment orders (CTOs) was written to annually with the offer of completing an advance statement with the support from independent advocacy and this includes in-patients. As such they were confident that everyone had been offered the opportunity to make one during the past 12 months. We were also told that this system is audited to ensure effectiveness.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found copies of the appropriate authorisation in place with the reasoned opinion, documenting that the individuals had been notified and made aware of their rights in relation to appeal and review.

We also found information available on noticeboards and leaflets, including pastoral care which was supported by ward staff where individuals wished to attend religious services.

There were also minutes of the weekly residents' meeting and survey questionnaires regarding food menus available on one of the noticeboards.

We found leaflets informing individuals about their rights, including the Commission's 'Rights in Mind' literature, as well as Forth Valley independent advocacy information leaflets, one of which discussed making an advance statement. We were also told that independent advocacy regularly visited the ward.

The Commission's *Rights in Mind*[1] 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

Since our last visit there had been the welcome addition of activity co-ordinators across the service. In keeping with other wards across the site, there was a range of occupational activities provided by OT, nursing and physiotherapy. Activity was available in the evenings as well as at weekends, when there may be less opportunity for some to occupy their time in a meaningful way. On the ward, people could participate in bingo, board games, table tennis, gardening and arts and crafts. Across the wider Bellsdyke site, the programme was detailed and included activities such as karaoke, smoothie making, board games, baking, physical activities and community outings.

On our last visit, we were aware that kitchen areas had been decommissioned, requiring individuals to visit a neighbouring ward to participate in kitchen assessments. We were pleased to learn that kitchens on both sides of the unit were once again operational. Individuals had free access to laundry facilities to further promote and develop independent living skills. One person spoke positively about their activity plan and how it was meeting their own needs and preferences.

The physical environment

The ward is split into houses that accommodates five women in two houses on one side of the building and six men in another two houses located on the other side. Bedrooms did not have full ensuite facilities, but each had a sink in the room. We had an opportunity to see inside some bedrooms and could see that they were clean, bright, spacious and that people had personalised their own rooms.

Environmental improvement work had commenced as part of the ongoing redevelopment of the entire Bellsdyke site which also aimed to reduce ligature risk, as highlighted in the previous report. It is hoped that as work continues, further consideration will be given to adapting individual bedrooms to incorporate full ensuite facilities. We viewed one vacant room which was the model for planned change. It included open shelving to reduce ligature risk but unfortunately, there was no provision for remodelling the room to integrate ensuite facilities at this time. We would encourage senior managers to reconsider this opportunity, as it would remove

[1] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

the need for individuals to share facilities and increase their dignity and privacy for individuals.

Another change observed was the repurposing of some bedrooms to allow them to be used as meeting rooms by removing some of the furniture. One of the rooms provided direct access to the garden area and this was a relaxing room that provided the opportunity for a more tranquil environment away from the larger communal lounges, if preferred. Despite being located closer to the female accommodation, both males and females had access to this room. The garden was a pleasant space that had been well maintained by both the ward community and estates department.

The communal living areas were spacious and benefited from a good level of natural light. We could see work had been done to add interest and soften the communal living spaces, with the addition of recently purchased adhesive, wipeable wall murals. This wildlife themed artwork was colourful and welcoming, cheering up the environment and giving the rooms areas of interest.

Any other comments

We were pleased to hear that the pilot scheme in relation to shift pattern changes appeared to be improving staffing levels and that funding for an additional substantive DCN had been approved, along with other successful recruitment. Besides mandatory online training, Trystview nursing staff could access additional fortnightly training delivered by the site wide DCNs. This training covered areas such as improving observation practice (IOP), infection control, room search procedures or other related topics as requested. Although of benefit to all, we feel that this would be especially helpful for newly qualified staff taking up post.

It is anticipated that the return of reflective practice and increased clinical supervision frequency will also drive ongoing improvement and safety.

Summary of recommendations

The Commission made no recommendations; therefore, no response is required. However, we would 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. We will contact the service in three months' time to gather feedback about this.

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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