Mental Welfare Commission for Scotland

Report on unannounced visit to: Bellsdyke Hospital, Russell Park, Kinnaird village centre, McIntyre Avenue, Larbert FK5 4SF

Date of visit: 27 June 2024

Where we visited

Russell Park is an 18-bedded, mixed-sex mental health rehabilitation ward on the grounds of Bellsdyke Hospital in Larbert.

On the day of our visit, the ward was split into two 'teams' which had males accommodated on one side, and females on the other. We were told that this was not always the case, and that sometimes males and females were accommodated together. In addition, all individuals shared the communal areas. This open ward enables individuals to transition from an inpatient setting to the community, following assessment and promotion of their independent living skills. Along with the three other wards on the Bellsdyke site, Russell Park can access three self-contained bungalows and four off-site flats that facilitate trial living for individuals who may benefit from this level of support during their ongoing recovery and preparation for discharge.

Our last visit to the ward in October 2022 was on an announced basis and we made recommendations about nursing care plans, advance statements, environmental issues and ligature risks. The response we received from the service included training, supervision and auditing of care plans, training in relation to advance statements, environmental assessment to ascertain and action environmental improvements and finally the commencement of a programme of works to address the ligature risks across the Forth Valley mental health inpatient units.

Who we met with

As this visit was unannounced, we were unable to meet ward staff and managers beforehand and we had limited access to individuals or relatives due to the short notice given to them.

On the day of our visit there were five people on in the ward, two in the community flats off site, and 11 vacant beds. Two individuals agreed to meet with us. We were also able to review the care notes of four people in total.

During our visit we spoke with ward staff including staff nurses, health care support workers and nursing students. Senior nursing staff and the activity co-ordinator were unavailable due to planned absence. However, the clinical nurse manager (CNM) based themself on site to support and attended for the visit.

Additionally, we had an opportunity to meet the service manager, consultant psychiatrist and learning disability manager via video conference at the end of our visit.

Commission visitors

Denise McLellan, nursing officer

Jo Savege, social work officer

What people told us and what we found

The individuals we spoke with were complimentary about the care they received with comments such as “the staff are great, friendly and approachable”, although one person wished to highlight that they were specifically referring to nursing staff. When we asked for some further information, we heard that the individual was unhappy with decisions about discharge planning as they did not agree with the views of the wider multidisciplinary team (MDT).

We were told that there were sufficient opportunities to speak to nursing staff on a one-to-one basis “when I need it” and “they have time to support me to be independent.” They also noted that the student nurses on placement appeared interested and keen to learn and that they were also friendly and approachable.

Another individual said that “the nurses are good, they have a flexible approach which is good for me” adding that food shopping, cooking and laundering arrangements worked well and that there was sufficient time to complete these tasks without feeling rushed. This person was unable to identify any area where they felt their care and treatment could be improved and told us that although they chose not to have a copy of their care plan, they were involved in developing it and could access it if desired. They also reported that their family had been involved in all aspects of their care. They told us that they were “quite happy to be here and it’s a good place to be.”

During the visit we were able to observe positive interactions between individuals and staff. One health care support worker (HCSW) described changes that had been made to the environment following recommendations made from the last visit. We were told that the ward had had an “abnormally quiet” couple of months following several recent discharges and there had also been a reduction in the number of bank staff used. This was attributed to a shift pattern change to long days which was being piloted across the inpatient areas and it had already appeared to have made an impact on the staffing resource.

Care, treatment, support and participation

Care records

Care records were held electronically on ‘Care Partner’. We found this electronic recording system relatively easy to navigate and we were able to access several key documents during our visit.

Records we reviewed were detailed and comprehensive, giving a sense of the person and a clear picture of their needs and goals. Documentation included care plans, risk assessment and management plans, crisis management and safety plans, care programme approach (CPA) meeting minutes, and multi-disciplinary team (MDT) meeting records.

Records cross-referenced other key documents and were written using person-centred language, evidencing progress or otherwise, with outcomes showing strengths and needs. The wording was inclusive and respectful with examples such as “please take these opportunities” and use of the word “consent”.

Continuous notes were positive, detailed and written using a team approach, with entries recorded by physiotherapy and the activity co-ordinator. Where activities were offered but declined, this was also captured. We found records of one-to-one contacts and there were entries recording informal peer support between individuals which was informative.

The standard tools to monitor physical health screening were available and completed in accordance with individual monitoring requirements.

Collaboration with family/carers was evident in one example where views were sought and considered in relation to an individual’s consumption of alcohol and how risk could be managed. This was documented in the care plan with discussion via the MDT process. It was clear that the MDT maintained regular phone contact with the individual’s family in relation to this aspect of care planning, with the individual’s consent for sharing of information.

For another, we saw evidence of education being given about schizophrenia in a meeting with the family. Additionally, written information that had been developed specifically for young people by the “young minds” organisation, was provided and behavioural family therapy (BFT) had also been discussed and offered. BFT is a practical skills-based intervention that promotes positive communication, problem solving skills and stress management within the family group. It delivers information and education to individuals and family members about mental health issues and treatment. This therapy was available and delivered by nursing staff based on the Bellsdyke site.

We also found a personal statement detailing an individual’s views and how they would like staff to help in addition to a recently completed “getting to know me” form which would assist future care providers about the person’s preferences using their words.

Nursing care plans

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. We expect to see patients participating in the forming and review of these care plans, to show how progress has been made towards the identified care goals.

On our last visit we recommended that these should include summative evaluations to clearly indicate the effectiveness of the interventions being carried out to meet care goals.

We were pleased to see that the care plans were comprehensive, person-centred and linked to the risk management plans. They were reviewed regularly and responsive to changes in needs and care delivery, with evidence of progress or otherwise. We saw evidence of patient and carer involvement in the process, both initially and during reviews and where individuals had agreed, evidenced by the inclusion of their signatures in the document which had been scanned and uploaded onto Care Partner. One individual confirmed that they were aware of and involved in the development of this aspect of their care and treatment.

Multidisciplinary team (MDT)
The ward had regular input from, psychiatry, psychology, occupational therapy (OT), nursing and physiotherapy. Individuals also had access to a community general practitioner (GP) who provided resource to the Bellsdyke site, however, GPs did not attend MDT meetings.

Although meetings were scheduled weekly, individuals were discussed and attended monthly. We were told that this enabled a more comprehensive discussion for everyone, however, where a requirement arose out with this timeframe, this was managed.

The MDT template used in other Forth Valley inpatient mental health units was also utilised in Russell Park. This framework facilitated a structured approach to the meetings, incorporating individuals' and relatives' views in relation to progress or concerns, admission information, legal status, specified person status, diagnosis, risk and medication. This 'live' document was prepared in draft form and shared at a pre-meeting, then finalised during the formal meeting, where it was displayed using a projector and screen in the meeting room for everyone to read.

Referrals to allied health professionals (AHPs) were also discussed in this forum. In addition to listing attendees, actions were recorded, and which key individuals were responsible for taking them forward identified. Risk updates and alerts were completed regularly using the multidisciplinary team (MDT) approach.

Use of mental health and incapacity legislation

On the day of our visit, five individuals were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Although

one of the individuals we spoke with was no longer detained, individuals understood their status. All documentation relating to the Mental Health Act was in place and accessible on Care Partner.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were printed out and kept in a folder in the treatment room however, two were not current certificates. We requested support to locate these on the electronic recording system, but these were not immediately obvious, and nursing staff sought clarification from the RMO.

The RMO shared the relevant documentation held on Care Partner during the feedback meeting and we were able to see that authority was in place and corresponded with the prescribed medication.

Nursing staff should ensure that relevant copies of certificates authorising treatment are available and referred to when administering medication.

Recommendation 1:
Managers should ensure that current copies of the T2/T3 certificates, authorising psychotropic medication are kept with the medication prescription sheets.

On the day, there were no individuals subject to Adults with Incapacity (Scotland) Act 2000 (the AWI Act) legislation, however, we saw evidence of a recent case conference for a guardianship application and were pleased to note that this had been a solution-focussed meeting.

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 an individual had nominated a named person, we found the paperwork relating to this stored on care partner.

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 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 the relevant documentation along with the reasoned opinion and information on the right of appeal, accessible in the records.

When we are reviewing files, we look for copies of advanced statements. The term ‘advance statement’ refers to written statements made under sections 275 and 276 of the Mental Health Act and are written when a person has capacity to make

decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. There were leaflets available in the foyer and nursing staff expressed awareness that they could support individuals to complete them, however, told us that individuals often expressed a preference to write these with advocacy support. We found that where relevant, a copy of the advance statement had been uploaded to the care record. One person told us of their choice not to have one, however were aware they could seek nursing staff support to develop one later if they wished to do so.

One of the individuals we met was aware of their rights, including their right of appeal when previously receiving compulsory treatment. They were however unaware of the availability of independent advocacy for those not subject to compulsory measures under the Mental Health Act. They considered this could be beneficial to support their attendance at future MDT meetings, which they found daunting at times.

The service manager confirmed at the end of the visit meeting that commissioning for this resource had changed, and it was now accessible for all, regardless of legal status. Nursing staff agreed to raise awareness with individuals who may potentially wish to be referred.

Although we were unable to find any leaflets advertising the service in the information stands, we were told that the ward welcome booklet was being redesigned and this information would be included. Nursing staff also agreed to contact Forth Valley Advocacy for more leaflets.

We did find entries in some continuous notes reflecting where people had accessed independent advocacy.

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

Although by the very nature and function of rehabilitation, many activities were often out with the ward environment, we were pleased to see that individuals had regular access to a balance of on and offsite community groups and activities. One individual told us that they enjoyed activities including walks and board games with others on the ward.

The activity planner was displayed in the main hall and in a communal area at the other side of the ward. Individuals were also provided with their own personalised timetables.

There was a good variety of activity on offer covering the seven-day period and the planner was up-to-, and colour co-ordinated, which helpful in making it easier to read. Groups/individual activities were facilitated by physiotherapy, nursing and OT and were a mixture of ward and site wide activities. This full programme was divided into morning, afternoon and evening and included ward-based activity such as art and crafts, bingo, and board games. There were also, gym sessions, horticulture therapy, litter picking, the freedom and mind choir, indoor bowls, cinema trips, poster making and karaoke; individuals could socialise with others across the site at a number of these activities.

We were also pleased to see that the outdoor area had been used to encourage physical activity. A badminton net had been set up on the lawn adjacent to the ward and table tennis equipment was located under the roofed patio at the entrance to the building. Walking was also promoted in the grounds via an accessible pathway.

Residents' meetings were weekly, and the minutes easily accessible and displayed on one of the more prominent notice boards. There was a clear sense of community, pride and ownership around the ward from simple tasks such as the completed charts for watering the plants and feeding the fish.

The physical environment

Our previous visit highlighted that people had been reluctant to move into the on-site bungalows, describing them as "dingy" and of the need to upgrade and soften the main ward communal areas. It was evident that positive efforts had been made to address the recommendation.

The layout of the ward consisted of two separate units categorised as male and female. Each unit had single ensuite bedrooms, communal sitting areas and separate kitchen and dining areas where individuals could prepare meals supported by staff. One room had been designated as the relaxation room with some sensory equipment available; it was also used on a sessional basis by nursing staff for relaxation groups. Additionally, there was a quiet room that could also utilised for family visits if preferred to visit in the main communal area.

The décor was bright and welcoming and the dried flowers on the door created a welcoming feel. There was clear signage and overall, there was a good use of space. There were several noticeboards with useful information about services, including information on the complaints process.

Staff told us that they felt the changes made had improved the environment overall, adding that it felt fresher and more homely. Although the cupboards were tidy and well organised, we were told that there was a lack of storage space and families were required to keep surplus items, depending on what individuals had brought with them to the ward on admission.

The ward had a garden area which was well maintained and was there creative use of this particular space. We were told that this was jointly maintained by estates and the ward.

One person had recently been discharged from one of the bungalows and we were able to visit, noting some of the improvements made since our last visit.

Each bungalow had been redecorated including the fitting of new carpets and replacement of other items such as crockery. White goods including a microwave, cooker and washing machine were of a reasonable age. Each bungalow was self-contained with an ensuite bedroom and had an open plan kitchen/dining/living space. There was ample storage from a wardrobe and chests of drawers. The ensuite wet room doubled as the main toilet and could therefore additionally be accessed from the main hallway. The bungalows had to their own individual garden area.

Any other comments

We were pleased to hear from individuals about the flexible approach taken to reflect changing needs and there was also a clear emphasis on participation and engagement of individuals and their families/carers. A positive culture where staff felt supported was described and we were told that decisions were considered, measured and accommodating.

We also heard that reflective practice was being reintroduced and that this would be provided by two psychology colleagues on a fortnightly basis. Information about this was clearly displayed to ensure that this was accessible to the staff group.

Summary of recommendations

Recommendation 1:
Managers should ensure that current copies of the T2/T3 certificates, authorising psychotropic medication are kept with the medication prescription sheets.

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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