

## **Mental Welfare Commission for Scotland**

**Report on announced visit to:** Ward 2, Clackmannanshire  
Community Healthcare Centre, Hallpark, Sauchie, Alloa, FK10  
3JQ

**Date of visit:** 10 January 2023

## **Where we visited**

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Ward 2 was a 20-bedded unit which provided assessment and treatment for older adults with dementia. The ward admitted both male and female patients. On the day of our visit there were no vacant beds.

We had not visited this ward for a number of years. On the day of this visit we wanted to review the care and treatment provided in the ward and hear how patients and staff had managed throughout the Covid-19 pandemic.

## **Who we met with**

We reviewed the care of seven patients and spoke with two relatives.

We spoke with the clinical nurse manager, the senior charge nurse, nursing staff, a student nurse and domestic staff in the ward.

## **Commission visitors**

Gillian Gibson, nursing officer

Juliet Brock, medical officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

Due to the progression of their illness, we were unable to have detailed conversations with patients, however, throughout the day we introduced ourselves and spoke to a number of patients; they were happy to engage with us. We observed the ward to be calm and patients appeared to be content and relaxed in the ward. We noted the positive interactions between ward staff and patients during our visit and it was evident from these observations and discussions with staff that they were enthusiastic regarding their patients and the care and treatment that they provided.

Feedback from the relatives we spoke to was generally positive. The care provided in the ward was described as “excellent”. We heard that the majority of staff were approachable and were described as “attentive and caring”. One relative we spoke to felt the communication with nursing staff was good. The other relative felt they had to work hard to get the level of communication they would have liked and an acknowledgement of their role, but told us that they were “getting there”.

Visiting arrangements continued to be supported and tended to take place in individual bedrooms. We heard there were two rooms available in the ward that could also be used for visits.

The patient group in the ward required a high level of support in all aspects of their care and treatment, including with personal care, dietary and fluid intake, mobility, physical healthcare and stressed and distressed behaviours. The ward establishment consisted of both registered mental health nurses (RMN’s) and registered general nurses (RGN’s) which we found positive in supporting the mental and physical health and wellbeing of the patient group. All registered nurses had also been supported to undertake specific training in relation to stress and distress. However, we heard from staff that although the ward had a good team, who communicated well and supported each other, staffing levels were often described as “challenging” particularly at meal times.

Due to the level of care and support patients required, staff felt they were often unable to provide regular meaningful engagement due to the staffing levels on the ward. One of the relatives we spoke to felt staffing levels were often lower at weekends. The ward tended to use bank staff to cover staffing shortfalls but had a core group of staff who regularly worked in the ward, to support continuity of care delivery. A workforce planning exercise had recently been carried out and requests had been made for an increase in the staffing establishment. This included a request for funding of a band 6 charge nurse post and an activity coordinator. We look forward to hearing how this work progresses.

### **Care records**

The mental health services in Forth Valley use the electronic system Care Partner to hold information on patient’s care and treatment. However, Ward 2 was not managed by the mental health directorate. As a result, documentation was completed on Care Partner and printed off for the nursing notes; which were held in paper format. Continuous care records were hand written and stored in individual patient profiles. We found some entries difficult to read. We

felt the current practice of working between two systems increased the risk of information being either missing or being out of date. We were also concerned that continuous care records would not be available to other parts of the service, particularly community mental health teams, when patients were discharged from the ward or required readmission to one of the mental health wards.

The ward used the Community Hospital and Care Plan booklet which incorporated all physical healthcare assessments required for this patient group. We found this booklet robust and well completed, with a clear focus on individual assessments and requirements for specific care planning.

We found there to be a good standard of record keeping pertaining to physical health and personal care, however, there was a distinct lack of meaningful person-centred information, in relation to social interaction, activity and mental wellbeing. There were sections in the care notes for family dialogue and social work dialogue that provided a detailed overview of communication with relatives, carers and social work colleagues.

The ward used stickers to document the use of as required psychotropic medication for patients experiencing stress and distress. We considered this was good practice and easily highlighted when medication was administered, the reason for this and the effectiveness of the medication. However, we were disappointed that we were unable to find any details of non-pharmacological approaches used to alleviate stress and distress before medication was considered and administered.

**Recommendation 1:**

Managers should ensure a review of the record keeping system is undertaken to ensure all information is current, up to date and held in one place.

**Recommendation 2:**

Managers should ensure that nursing documentation complies with the Nursing and Midwifery Council record keeping standards with continuous care records providing a detailed holistic account of patient's physical and mental wellbeing.

**Care planning**

The ward used a stress and distress symptom scale which informed specific stress and distress care plans. We found good evidence of formulation to identify potential causes of stress and distress and were able to see how this was used to create person-centred care plans. Overall we found the standard of these care plans to be good, however, we found two different templates used. We found one of the templates more robust in detailing person-centred information and non-pharmacological interventions for managing stress and distress behaviour. We discussed this with senior staff on the day of our visit.

We found a range of care plans that addressed mental health and physical health needs, however, these were variable in quality. We were pleased to find they were generally written in the second person but felt the majority lacked meaningful person-centred information. Some patients had care plans in place with no identified interventions to meet care goals.

When we reviewed the care plans we were unable to locate robust summative reviews that targeted nursing intervention and highlighted individuals' progress. We would have expected to see a detailed summary of the care plans, documenting what progress had been made to meet specific goals, and which interventions had been effective.

We heard that relatives were not involved in care planning and we were unable to find evidence of relative involvement in the care plans we reviewed. Where patients were unable to fully participate in care planning due to the progression of their illness, we would have expected these to be discussed and agreed with relatives and carers.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

<https://www.mwcscot.org.uk/node/1203>

**Recommendation 3:**

Managers should ensure nursing care plans are person-centred, contain individualised information, reflect the care needs of each person and identify clear interventions and care goals.

**Recommendation 4:**

Managers should ensure that nursing staff include summative evaluations of care plans in patient notes that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

**Multidisciplinary team (MDT)**

The ward had an MDT consisting of nursing staff and a consultant psychiatrists who attended the ward one day per week. There was an occupational therapy (OT) assistant who provided input to the ward one day per week and an OT who attended MDT meetings. We heard that prior to the Covid-19 pandemic, the ward had regular input from psychology, however since the pandemic, this had reduced to referral basis only. Referrals were made to other services, such, speech and language therapy and dietetics as and when required, and we saw evidence of involvement in the care records. Pharmacy advice and support was available on an as-required basis. General practitioners and advanced nurse practitioners provide physical health care and treatment to patients in the ward and attend Ward 2 from Monday to Friday.

We found a good MDT summaries completed by the psychiatrist following ward rounds that were recorded on an MDT contact record and then printed off for the individual files. This detailed the patient's legal status, the legal authority in place for their care and treatment and a clear update on the individual's progress in the ward and the ongoing plan of action. We found a robust MDT pro-forma for meetings on Care Partner which was not used. This template allowed for members of the MDT to pre-populate summary's and reports prior to the meeting which would then be completed following MDT review. We discussed this with senior staff on the day of our visit and suggested consideration be given to implementing this pro-forma which would enable information sharing at MDT's and discussions to be captured in a more robust and streamlined manner. This would ensure all information was held on one document and reduce the risk of misplacing any reports or information prepared for the meeting.

On the day of our visit, there were nine patients whose discharge had been delayed. We heard this was mainly due to applications for welfare guardianships and availability of appropriate care home placements. However, we were pleased to hear that a social worker from Clackmannanshire Council attended MDT meetings on a regular basis and heard there were no delays in the allocation of social workers. We were advised that daily meetings were also held with social work colleagues with a focus on delayed discharges.

We heard that relatives and carers were not routinely invited to attend MDT meetings and we were unable to find any evidence of relative carer involvement in the files we reviewed. We heard that relatives have to request meetings with medical staff as these are not consistently offered.

#### **Recommendation 5:**

Managers should ensure that, where appropriate, relatives/carers are included in the planning and review of their relative's care and treatment.

### **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. The forms authorising treatment (T3) were available and in order.

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 (AWIA) must be completed by a doctor. The certificate is required by law and provides evidence that the treatment complies with the principles of the Act. Consent to treatment certificates were in order along with accompanying care and treatment plans, which detailed specific treatment covered by the certificate. These were not always discussed with relatives or welfare proxies.

There appeared to be a clear process to identify where there was a welfare proxy (guardian or power of attorney) in place; details were recorded and we were pleased to find copies of powers in place available in individual files.

### **Rights and restrictions**

Ward 2 operated a locked door, commensurate with the level of risk identified with the patient group. This information was clearly displayed in the ward on the day of our visit.

We saw evidence of individual risk assessments that linked to the care plans. However, these were not all available in the paper files. We also found some of these had not been reviewed for a significant period of time. We spoke to senior staff on the day of the visit and advised them to ensure that these were updated as soon as possible.

We were pleased to hear that advocacy services had resumed face-to-face visits. We heard that patients were referred to advocacy services by staff, and we were able to see advocacy involvement and representation at mental health tribunals.

Where patients were receiving their medication covertly, were found the appropriate care pathway in place. However, these were not all dated and signed and some lacked evidence of discussion with relatives and welfare proxies. The care pathway review template was used but some had not been reviewed in the timeframe identified. Again, we advised the senior staff that these documents should be updated.

One of the relatives we spoke to told us there was no carer support offered by the ward and they felt they would benefit from support from staff to identify their needs and provide and share information on a regular basis.

The Commission has developed [\*Rights in Mind\*](#). This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at:

<https://www.mwcscot.org.uk/law-and-rights/rights-mind>

## **Activity and occupation**

Ward 2 did not have a dedicated activity co-ordinator. An OT assistant attended the ward to carry out activities one day per week. Nursing staff would try to offer activities on an ad-hoc basis but due to the complex clinical need of the patient group, coupled with staffing challenges, these were often unable to be delivered. We heard from both staff and relatives their concerns about the distinct lack of activity offered in the ward. We heard that a community art group attends the ward regularly as well as a therapy pet but we were unable to find any evidence of activities offered or undertaken in patient notes. We were told that this is recorded in a separate folder in the ward but we did not have the opportunity to see this on our visit.

We were aware that funding had been requested for an activity co-ordinator but ward managers were unsure as to the timeframe for this post to be advertised and appointed to.

Stress and distress formulations and subsequent care plans often identified an unmet need of activity and occupation and we felt that the patient group would benefit from regular OT input.

### **Recommendation 6:**

Ward managers should ensure that there is a structured, scheduled, meaningful activity programme available to patients seven days per week and provisions are put in place to support meaningful activity in the absence of an activity co-ordinator.

### **Recommendation 7:**

Ward managers should review the occupational therapy input to the ward to support assessment, activity and occupation for the patients' group.

## **The physical environment**

The layout of the ward consisted of 20 single rooms with en-suite facilities. Bedrooms had a whiteboards in each room detailing a person-centred life stories, likes and dislikes. Relatives and carers were encouraged to bring in photographs and personal items into the ward to make rooms more homely and meaningful for each patient.

We found the ward to be bright, spacious and well maintained. The ward felt calm on the day of our visit. It was well decorated and there were sensory stimulating wall mounts and items of interest to occupy patients around the ward. Dementia-friendly signage supported orientation throughout. Patients had access to three sitting rooms in the ward and there was a separate dining room for mealtimes.

The ward had access to a large garden which was also well maintained with plenty of seating for patients and relatives to use.

## **Summary of recommendations**

### **Recommendation 1:**

Managers should ensure a review of the record keeping system is undertaken to ensure all information is current, up to date and held in one place.

### **Recommendation 2:**

Managers should ensure that nursing documentation complies with the Nursing and Midwifery Council record keeping standards with continuous care records providing a detailed holistic account of patient's physical and mental wellbeing.

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## **Service response to recommendations**

The Commission requires a response to these recommendations 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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