mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on unannounced visit to: Wards 4 and 5, Forth Valley Royal Hospital, Stirling Road, Larbert FK5 4WR

Date of visit: 5 January 2016

Where we visited

Wards 4 and 5 are both 20 bed mixed sex old age psychiatry admission and assessment units. Ward 4 caters specifically for individuals with a diagnosis of dementia, and ward 5 for patients with a functional illness and milder cognitive impairment.

We last visited this service on 26 March 2014 and made recommendations in relation to:

- Safeguards for compliance with treatment being provided under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or part 5 of the Adults with Incapacity (Scotland) Act 2000 (the Adults with Incapacity Act) s47
- Person centred nursing care plans, with particular reference to stressed and distressed behaviour
- Activities, for both groups and individuals

On the day of this visit we wanted to follow up on the previous recommendations.

Who we met with

We met with 11 patients from both wards and the relatives of two patients in ward 4.

We spoke with the service manager, the clinical nurse manager, the senior charge nurse for ward 4, the acting charge nurse for ward 5, consultant psychiatrist and a junior doctor.

Commission visitors

Susan Tait, Nursing Officer (co-ordinator)

Margo Fyfe, Nursing Officer

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

In our previous report there were two recommendations related to nursing care plans. We received written feedback from the clinical nurse manager on 1 October 2014 indicating that there had been progress with this and a workshop had taken place which highlighted a need for person centred care and that this was a priority area. The overall aim was for a much higher-standard care plan. This was not in evidence in the care plans we reviewed on the day. They did not contain a detailed description of nursing intervention to alleviate distress for individual patients. There were statements such as ‘use de-escalation’ which did not provide information on

what specific de-escalation techniques were appropriate for the patient. This was the case in most of the plans we reviewed on both wards. There was minimal evidence of attempts to involve patients in their care, particularly in ward five where we would expect to see participation.

There is a new electronic system for recording care. We were told that this is used by most disciplines. However, medical staff do not access it at present. This has the potential for communication errors which in turn carries risks for the delivery of care.

There were, however, detailed and informative recordings of the multi-disciplinary meetings and in the day-to-day notes.

There was good attention to physical healthcare in both wards.

Recommendation 1

Senior nursing staff should ensure that care plans are person centred and address all of the individuals care needs. They require detailed descriptions of the nursing interventions required to inform the delivery of care. These should be evaluated on a regular basis with summative evaluations documented.

Recommendation 2

Managers should consider how to ensure consistency of care recording on the new electronic system.

Use of mental health and incapacity legislation

In ward 5 there were no Adult with Incapacity Act s47 certificates for those patients who had been assessed as lacking capacity to consent to treatment.

There were two patients in ward 4 who had granted Power of Attorney to relatives. The documentation relating to the powers granted were not in the files, therefore could not be assumed as being in place. These issues were discussed with charge nurse on the day and she agreed to progress this.

It is concerning that issue regarding Adults with Incapacity Act s47 certificates require to be reiterated.

Recommendation 3

Systems must be in place to ensure that where treatment is being provided under the Mental Health Act or part 5 of the Adults with Incapacity Act, the requirements of the relevant acts are fully complied with and relevant safeguards are in place. This is a repeat of the recommendation made in the previous report.

Rights and restrictions

In one of the prescription sheets reviewed an informal patient had been prescribed intramuscular (IM) medication for agitation. We discussed this with the doctor and confirmed that this would not be best practice as it would be unlikely that this would be administered under conditions of consent. If the patient was so distressed and exhibiting behaviour which caused concern then their legal status would need to be reviewed. The medication was discontinued.

Recommendation 4

Medical staff only prescribe IM medication where there is lawful authority to do so.

Activity and occupation

Wards 4 and 5 have input from occupational therapy (OT), the equivalent of two full time and one part time. There is also the equivalent of one full time and one part time physiotherapist. .

We were told that OT staff will see all patients as clinically indicated.

On the day of the visit the OT support worker had initiated a light exercise group in ward 4 but it was clear from the day to day notes and of the patients we reviewed that there was very little in the way of meaningful activity. Two patients on ward 4 who were able to give us their view told us that there was very little activity and they were bored. This level of input is unacceptable, particularly in an assessment war.

Recommendation 5

Managers review the multi-disciplinary input to ward 4 to be assured that patients with dementia are receiving an equitable service.

The physical environment

The environment in both wards is clinical, stark and confusing. There is minimal signage to aid orientation. In particular the sitting rooms are unwelcoming and uncomfortable with only upright chairs arranged around the walls. There is some artwork which has been commissioned but this has a very limited impact on the overall appearance of the wards. This same issue has already been raised in relation to the other mental health wards in Forth Valley Royal. We were made aware that there have been discussions about the environment with Serco, the private finance company (PFI)

Recommendation 6

Hospital managers have further discussion with Serco about how the environment can be changed in order to provide a more appropriate setting for the provision of care for patients with mental illness and/or dementia.

Any other comments

On the day of the visit we were made aware that it was a very busy day. One of the wards had a patient transferred to accident and emergency following an incident and the wards had new students starting. Both wards have just recently appointed senior charge nurses.

We were present around the ward during the handover period where there was little evidence of nursing staff on the ward. We noted that during this time there were seven patients in the sitting room. One of the patients was asleep and bent over nearly falling out of his chair and another patient was trying to help him sit up. We therefore intervened and called for nursing assistance. A member of staff came in, helped the man sit up, and then left the room. This raises concerns for patient safety particularly in such a vulnerable group of patients.

The ward was noisy and we observed staff shouting down corridors and banging doors. This does not provide a calm atmosphere to enable assessment and reduce stress for patients.

The office had a board with all of the patients' full names, detention and 'do not attempt resuscitation' status. There was also information next to names, entitled 'agg', which indicated that the patient was aggressive. This information was easily seen by anyone entering the ward. This is a breach of confidentiality and an inappropriate use of language to describe behaviour.

The two relatives we met both had relatives on ward 4. One was very positive and spoke highly of the care their father had received. The other one raised concerns about access to information and inconsistency in communication. We discussed this on the day with the senior charge nurse and were told that there had been family meetings to try to address this.

Recommendation 7

Senior nursing staff should review patient safety, particularly when there is a reduced number of staff on the ward.

Recommendation 8

Nursing staff should review how important information can be reviewed and presented in a non pejorative way which is readily available without breaching confidentiality.

Summary of recommendations

1. Senior nursing staff should ensure that care plans are person centred and should address all of the individuals care needs. They should have detailed descriptions of the nursing interventions required to inform the delivery of care. These should be evaluated on a regular basis with summative evaluations documented.
2. Managers should consider how to ensure consistency of care recording on the new electronic system.
3. Systems must be in place to ensure that where treatment is being provided under the Mental Health Act or part 5 of the Adults with Incapacity Act the requirements of the relevant acts are fully complied with and relevant safeguards are in place. This is a repeat of the recommendation made in the previous report.
4. Medical staff only prescribe IM medication where there is lawful authority to do so.
5. Managers review the multi-disciplinary input to ward 4 to be assured that patients with dementia are receiving an equitable service.
6. Hospital managers have further discussion with Serco (PFI) how the environment can be changed in order to provide a more appropriate setting for the provision of care for patients with mental illness and/or dementia.
7. Senior nursing staff should review patient safety, particularly when there is a reduced number of staff on the ward.
8. Nursing staff review how important information can be reviewed and presented in a non pejorative way which is readily available without breaching confidentiality.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report, apart from recommendation 7 which we would like a response to within six weeks.

The issues in this report are to be directed to the General Manager and the Nurse Director because we were not satisfied with the previous response, and our concerns about patient safety.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Mike Diamond

Executive Director (Social Work)

18 March 2016

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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