Mental Welfare Commission for Scotland

Report on announced visit to:
Bo’ness Community Hospital, Ward 2, Dean Road, Bo’ness, EH51 0DH

Date of visit: 22 October 2024

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission’s good practice guides.

Where we visited

Ward 2 is a 16-bedded unit, providing assessment and treatment for male and female patients with a diagnosis of dementia. It is located in Bo’ness Community Hospital, a relatively modern facility providing psychiatry and other services for older adults. Although the unit was opened in 2004, there has been a local hospital in the Bo’ness area for over 100 years and despite changes in provision, efforts have maintained close community links.

On the day of our visit, there were no vacant beds. Of the 16 individuals on the ward, 11 were formally recorded as having their discharge delayed. This occurs when an individual is clinically ready to leave hospital, however, they are unable to leave hospital due to a lack of available care, support or accommodation. We were told eight people were waiting for a care home placement and another three people were awaiting completion of welfare guardianship applications to provide the legislative framework for future care.

We last visited this service in November 2022 on an announced visit and made recommendations on the record keeping system, care planning, liaison with social work in relation to discharge planning and authorisation of psychotropic medication. The response we received from the service was that the record keeping system would be reviewed in consideration with wider systems used by mental health services in NHS Forth Valley and Falkirk Health and Social Care Partnership (HSCP). A tool for audits would be devised, and further training delivered to improve standards of documentation and care planning to provide assurance.

As the primary route for social work involvement, the ‘home first’ team would be alerted to gaps in provision or caseload issues for escalation. Social work involvement and the actions agreed would be monitored through multidisciplinary and discharge meetings processes. Weekly reviews by the senior charge nurse (SCN) and deputy senior charge nurse (DSCN) would ensure all prescribed psychotropic medication was legally authorised.

On the day of this visit, we wanted to follow up on the previous recommendations and meet with people receiving care and treatment on the ward.

Who we met with

We met with and reviewed the care and treatment of seven people, along with five relatives.

We spoke with the clinical nurse manager (CNM) and SCN remotely via a MS Teams meeting prior to the visit. In addition, we had a telephone call with a representative of Forth Valley Advocacy prior to our visit.

Commission visitors

Denise McLellan, nursing officer

Tracey Ferguson, social work officer

Sandra Rae, social work officer

What people told us and what we found

Due to the progress of peoples' illness, we were unable to gather people's views regarding their care and treatment and whether their rights were being upheld. We were, however, able to observe interactions throughout the day and overall, people looked calm, settled and well-cared for. It was apparent that individuals had positive relationships with staff, and we saw examples of one-to-one interventions supporting people to feel safe around the ward.

One person told us the food was of a good standard but they found the dining area noisy. They particularly enjoyed walks in the garden and sometimes were able to go out to a café in the local community with staff. Another person said staff would do anything for them when asked.

During the day there was a significant presence from relatives and carers, and we were fortunate to be able to speak with some. They were all complimentary and told us staff made them feel included in most aspects of their relatives' care and treatment, "they can't do enough", "they are lovely, kind and caring". The relatives told us that regular updates ensured they remained involved, felt supported and listened to.

One relative described the ward as welcoming and appreciated being able to visit anytime. They found staff "marvellous and supportive" and said that they were kept up to date, with contact made with them if any incidents occurred and also being kept informed about the outcome of MDT meetings. Despite being aware that their relative would soon be clinically ready for discharge, they did not feel unduly pressured and told us they had been given a copy of care plans so they could understand the purpose of admission. The relatives highlighted that they had found the mental health officer (MHO) very supportive.

Another relative spoke of their admiration for staff and how they were supported to remain involved and actively support their relative's mealtimes. They felt included in all aspects of care and decision-making and told us they were kept informed, and that communication was of a high standard, enabling a better understand of legal status and needs. They also described a positive relationship with their relative's responsible medical officer (RMO).

One relative told us the buzzer system in their relative’s room had been broken for around three weeks; we discovered this was not isolated to one room. Staff informed us this had already been reported to the estates department, however, would be escalated as a matter of urgency.

We were told that relatives were generally given updates when visiting, however, when this was not achievable, updates would be provided through phone contact. The consultant psychiatrist visited the ward weekly and where more complex discussion was required, there was an opportunity to meet up to two families each week.

Advocacy informed us of their regular presence on the ward and positive feedback from their observations of individuals, who they thought were treated with dignity, respect and were well cared for. They told us that they found the environment to be clean, free from odours and welcoming. In general, advocacy referrals were made by social work professionals when Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) case conferences were required. Nursing staff had an understanding and awareness of the independent advocacy role, and the relationship was a positive one. Advocacy also commented that the addition of the activity co-ordinator was helpful.

Care, treatment, support, and participation

There was a care plan booklet bundle which was thorough and holistic. The emphasis of the booklet was on care and treatment which was beneficial, given the significance of physical health in older people with dementia.

Care records

On our last visit, we recommended that the system of storing records should be reviewed, to ensure that all information was current, up to date and held in one place.

Since then, we could see that action had been taken to address concerns we highlighted. Individual records had been partially transferred to Care Partner, the electronic health record management system in place across NHS Forth Valley. The system was relatively easy to navigate, and held information about assessment, the multidisciplinary team (MDT) meeting record, the functional analysis of care environments risk assessment tool (FACE) and care plans.

However, the system was not used comprehensively, as we found that daily continuation notes contained in paper files which caused a mix across two separate systems. This increased the likelihood of duplication and created a difficulty in locating information. This created a risk, as pertinent information was not easily accessible for those involved in the delivery of care and treatment, potentially increasing the possibility of individuals’ care needs not being met.

Recommendation 1:
Managers should ensure a further review of the record keeping system is undertaken to ensure all information is current, up to date and held in one place.

Continuation notes were of a variable quality, with some only giving a general overview of routines, such as receiving medication, personal care; they lacked detail regarding an individual's presentation throughout the day. The use of language such as "disgruntled" was not in keeping with what would be expected for individuals who experienced stress and distress symptoms.

Recommendation 2:
Managers should ensure that continuation notes are detailed and enable clear interpretation of clinical presentation, progress and ongoing challenges for the individual.

We did see that incidences of verbal and physical aggression were appropriately reported on the 'DATIX' incident reporting system.

There was evidence of comprehensive physical healthcare monitoring captured in the community hospital assessment and care plan booklet. Information was collated using assessment tools to inform care planning, with a focus on a range of physical healthcare needs such as skin integrity, the risk of falls, nutrition, elimination, hygiene, cognitive assessment and discharge planning.

We found evidence of good physical health care monitoring, with referrals to specialist services where needed.

Separate stress and distress care plans were available on Care Partner, and these were reviewed monthly. They included triggers and effective interventions to help manage behaviours. The system provided a prompt to notify when reviews were due. Care plans were printed off and stored in a separate folder, however, not all of them were available in this format.

We found that care plans were of a good standard and were linked to risk assessment. They were person-centred and comprehensive using information from assessment augmented by knowledge gathered about the individual from relatives and carers. The stress and distress care plans were personalised and proactive, detailing how symptoms could present and what the triggers for distress were. The care plans identified unmet needs and planned interventions. We saw evidence of regular reviews.

Families were encouraged to complete 'Getting to know me' booklets providing detailed information with the aim of promoting person-centred care specific to their loved one's individual preferences. There were also family recording sheets to note discussions with families following on from MDT meetings.

Do not attempt cardiopulmonary resuscitation (DNACPR) paperwork was available and in order. We could see that relatives had been consulted in this process.

In addition to the documentation held on the IT system and the handwritten files, we observed an information whiteboard located in the nursing office. It captured details including admission details, legal status, DNACPR status, risks, medication authorisation and whether being given covertly, discharge planning status and key professionals involved. It recorded whether an individual was subject to incapacity legislation, specifying what this meant making the data clear and useful at a glance.

The Commission has published a good practice guide on care plans[1]. 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.

Multidisciplinary team (MDT)

MDT meetings took place weekly with half the individuals reviewed on alternate weeks. The MDT had representation from psychiatry and nursing. Occupational therapy (OT) and physiotherapy were not directly involved but could provide updates when they provided treatment to individuals. Social work and pharmacy also attended where required. The SCN informed us that there were weekly liaison meetings with the home first team to discuss allocation.

There was no psychology provision on the ward, but we were told referrals could be made to the older adult psychology service in Forth Valley Royal Hospital. We were pleased to hear there had been an increase in nursing staff since our last visit, which included registered nurses and health care support workers (HCSW). Registered staff consisted of mental health and general adult nurses.

The MDT meeting template on Care Partner was robust and provided structure with prompts such as risk assessment, medication and other items governed by specific legislation. The updates were informative and included details of attendees, discussion and action planning. Treatment was discussed and reviewed along with risk assessment and management planning and actions being taken forward.

We saw evidence of discussion with families to consider next steps but noted they did not attend the formal MDT meeting. Documented evidence of relative/carer participation and involvement in aspects of care and treatment was variable, however, we saw a good example of discussion with a relative resulting in agreement to provide updates by phone calls in place of some visits. This was felt to be more beneficial for the individual and supportive of the relative who had found visits had become more of a challenging.

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[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Use of mental health and incapacity legislation

On the day of our visit, 10 individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and another under the Criminal Procedure (Scotland) Act, 1995 (the Criminal Procedure Act). Documentation relating to detention was in place in the electronic files and was up to date. There were also copies held in some paper files.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those detained individuals, 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 held on Care Partner and corresponded to the medication prescribed, except for one, where a prescribed ‘as required’ medication was not authorised. We discussed this with the SCN who agreed to raise this with medical staff to have this rectified.

When reviewing the certificates we noted that only some copies had been printed and stored in the folder kept alongside medication. Nursing staff are responsible for ensuring that the medication they administer is legally authorised, so should have this information readily available to them before doing so. We discussed this with the SCN who arranged for the missing certificates to be printed out immediately.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 found that three of the 16 section 47 certificates were out of date and a further one was due to end following day. The completion of the certificates was variable, with some having no record of discussion with the nearest relative or identifying who this was. Dates confirming consultation had been omitted on some. We did see some examples of comprehensive certificates that included associated treatment plans.

Recommendation 3:
Managers should ensure that where a patient lacks capacity in relation to decisions about medical treatment, section 47 certificates, and where necessary, treatment plans must be completed in accordance with the AWI Code of Practice (third ed.) and cover all relevant medical treatment the individual is receiving.

Recommendation 4:
Managers should ensure that where a proxy has powers to consent to medical treatment this person must be consulted, their consent sought and that the process and outcome is clearly recorded.

We looked for copies of power of attorney and welfare guardianship certificates however, not all were available where they should have been. This was a concern as without these, how would the MDT know which specific powers had been granted? Additionally, we saw a tick box relating to whether a person was subject to incapacity legislation with no differentiation about what this was. Nursing staff need to remind proxy decision makers that they must provide a copy of the relevant documentation. We highlighted these issues in our feedback at the end of the visit. There was a prompt on the MDT template, which would have ensured that this is being reviewed regularly.

Recommendation 5:
Managers should ensure that when a welfare proxy is in place for an individual, a copy of the document stating the powers of the proxy is obtained for their records.

Medication can be administered covertly when an adult refuses treatment. To enable this to done safely and effectively, a covert pathway is developed along with a corresponding care plan. This process should be reviewed regularly. In one case, covert medication was recorded on the front of one paper file, however on reviewing the notes held on the electronic system, this was no longer in place; we found this confusing. Using the pathway ensures consultation between MDT and any proxy decision maker/relative, with specific input from pharmacy, however, there was no discussion with the proxy recorded.

Recommendation 6:
Managers should ensure that the need for covert medication is regularly reviewed at MDT meetings. Adherence to the pathway is necessary for safety and ensuring all required parties are consulted.

The Commission has produced good practice guidance on the use of covert medication.[2]

Rights and restrictions

Due to the level of risk associated with extent of some individuals' illness and vulnerability, Ward 2 operated a locked door. A notice was displayed on the door and explained that this was in accordance with policy.

Records included information about referrals to independent advocacy and legal representation to support the right of appeal to the Mental Health Tribunal for

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[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

Scotland (MHTS). We also saw use of a curator ad litem where a person lacked capacity to instruct a solicitor.

We found the documentation recorded time off the ward through the MDT meeting process.

Activity and occupation

The ward had a dedicated full time activity co-ordinator who worked closely with the OT assistant. Provision of activities was Monday to Friday with nursing staff providing opportunities for activity at weekends. Activities included visiting cafés, music, pet therapy, flower arranging, art and crafts, coffee mornings, and spending time in the garden. On the day of our visit the ward was actively preparing the environment for a seasonal celebration which involved making the decorations for the ward.

We found that although activities were recorded, there was a lack of detail about how they benefitted an individual and appeared to be documented as a list, rather than how they linked to supporting a non-pharmacological approach to the management of stress and distress. Additionally, where activity was declined it did not specify what activity had been offered.

Recommendation 7:
Managers should ensure that activity participation is recorded and evaluated or documented where this has been declined.

The physical environment

The entrance to the ward was welcoming with a memory tree for families to add their thoughts and feelings regarding their loved ones. There was also information about the ward in the reception area.

The ward layout consisted of 16 single rooms with toilet facilities. The sleeping accommodation was divided into two, and each side had its own shower and separate bathroom. We asked whether there were any issues with the layout, however, were told this was not the case as people were supported to maintain their personal hygiene throughout the day, in keeping with their preference.

Bedrooms were clean and personalised, with belongings such as photographs, televisions and radios. Each door had information to assist identification, including door number, a picture and the person’s name. Whiteboards with relevant information, such as likes and dislikes, ‘what matters to me’, meals times, and staff names could be accessed immediately which was helpful for engaging and connecting people with their own histories.

The environment was clean, bright, well organised and well maintained with good signage to assist orientation. Communal spaces included a dining area and separate day areas with numerous interactive equipment, pictures, two televisions and a clock with the date.

On the day we visited, staff were decorating the ward and individuals were assisted to participate where able. The meal choice was displayed on a large board and the choice looked varied and nutritious. There was also helpful guidance for choking incidents displayed nearby. The activity room was tidy and well equipped. We also saw a room that the activity co-ordinator used as a hairdressing salon so that individuals could maintain an interest in their appearance and improve their self-esteem. During the Covid-19 pandemic a designated staff wellbeing area was created; we were pleased to see that this has been maintained.

The ward garden was large and accessible by wheelchair, with handrails fitted to reduce the risk of trips and falls. It was renovated using National Lottery community funding and with help from volunteers. It was maintained by volunteers and staff who kept it well stocked and cheerful with numerous raised beds, benches and fencing painted in dementia friendly colours.

Families were encouraged to use the garden for visiting when weather permitted. We saw several plants that had been gifted by relatives of people who had previously been in the ward. There was also a large greenhouse and a summer house that had been converted to a vintage ‘sweet shop’ but unfortunately, this was not in use due to damage to the floor. We were told that the ward was hoping this could be repaired in time for use in the summer months.

Any other comments

The layout of the ward and the staffing levels allowed for one-to-one support for individuals who required this at times of stress and distress. Relatives told us that open visiting encouraged additional support and for them to remain involved in caring and decision-making, which lessened distress for individuals. This was a positive example of healthcare and families working together to maximise the outcome for the individual.

Summary of recommendations

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Recommendation 2:
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Service response to recommendations

The Commission requires a response to these recommendations 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 an individual's care, treatment, and support are 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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