# Mental Welfare Commission for Scotland

## Report on an announced visit to:

Forth Valley Royal Hospital, Ward 5, Stirling Road, Larbert,
FK5 4WR

**Date of visit:** 22 July 2025

**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 5 is a mixed-sex, 24-bedded unit for older adults from the Falkirk, Stirling, and Clackmannanshire council areas. It provides assessment, care and treatment for individuals experiencing functional illness and individuals with an early diagnosis of dementia.

We last visited this service in October 2024 on an unannounced visit and made recommendations including ensuring consistency in the system used to review documentation, including person-centred care plans. Additionally, we recommended that participation be clearly recorded to evidence individuals' understanding of treatment and discharge plans and that individual preferences were considered when providing activity. We also made recommendations about the legal authorisation of medication and compliance with smoking legislation.

The response received was that documentation was being reviewed and a template developed to ensure key information was recorded with weekly auditing to monitor compliance. Key information would also be included on the safety briefs for handover between staff. Further guidance would be given about the expected standard of care planning with support to achieve this. Individuals would be offered choice regarding participation in the multidisciplinary team (MDT) meeting, including gathering their preference for one-to-one feedback post meeting or attendance at the weekly meeting. Medication consent and authorisation would be reviewed at the weekly meeting and audited monthly to ensure it was available and corresponded with all medication prescribed.

Improvements to activity provision were made as part of the "safer together" collaborative. On admission to the mental health unit, individuals are given an activity preference sheet. This completed document is used during MDT meetings to incorporate information into activity care plans. An activity station was set up in the ward with accessible activities available, including crosswords, brain games, quizzes, jigsaws, dominoes and playing cards.

We were pleased to see that all wards in the mental health unit were now supporting individuals to comply with legislation that prohibits smoking in hospitals. An MDT approach was adopted promoting health benefits through education, therapeutic activity and availability of smoke cessation products. The World Health Organisation's 'World No Tobacco Day' on 31 May 2025 was chosen as the launch date.

### Who we met with

We met nine individuals and reviewed the electronic care records of eight people in total, some of those whom we met in person. We also met with four relatives.

Prior to our visit, we had a virtual meeting with the deputy senior charge nurse (DSCN) and the clinical nurse manager (CNM). We spoke with staff during the visit, including the service manager (SM), the chief nurse for MH and LD nursing, the occupational therapist (OT) and the allied health practitioner (AHP) co-ordinator for older adults, who joined the virtual feedback meeting at the end of the day.

## Commission visitors

Denise McLellan, nursing officer

Juliet Brock, medical officer

Gordon McNelis, nursing officer

Audrey Graham, social work officer

## What people told us and what we found

On the day of our visit, there were 21 people in the ward, 12 of whom were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Four individuals were considered to have their discharge from hospital delayed. Delayed discharge occurs when an individual is clinically ready, however, unable to leave hospital due to a lack of necessary care, support or accommodation available. We were told that a lack of care home placements was the reason for delay in each case. Dynamic discharge meetings continued weekly to monitor and manage progress. We were told that in total, 10 adults had admission periods exceeding 80 days due to lack of placements, acuity and for one person, repatriation to their home country that had necessitated the involvement of several agencies which had contributed to the length of admission.

We heard positive comments from individuals about the staff, with one person who was admitted two weeks earlier telling us that “you couldn’t fault them, they’re excellent” adding that they felt listened to, respected and since coming into hospital they were able to measure some improvement in themselves, such as “I’ve got my appetite back, I’m eating more than I ever did in the house, the food is good”. They did comment that the bedding was thin, and it could be cold at night.

Another person told us that “staff are wonderful, I think they have done everything they could” and that “the staff are lovely, and the meals are alright. There’s not much to do but they do put things on right enough”. Another told us that “staff are nice, and I can speak to them if I want to and they manage situations between other patients, I feel safe.” One health care support worker (HCSW) was singled out for their attentiveness and caring demeanour “he is very warm and considerate to patients.” They discussed a time when reassurance was needed, and he took their hand and took his time with them. This was described as “more than once, that’s just how he is, nice all the time.” We gave this feedback to the team at the end of the visit.

We heard comments relating to the physical environment being noisy and “the windows in the bedroom don’t open and there’s no TV in the room and the bed is not very comfy”. Another person referred to not having a television in their room but said they understood that someone else had a greater need. Although there was a television in the main lounge, the room filled quickly so they asked a relative to bring them a radio to use in their own room.

One person said they had been oriented to the ward but would have appreciated a welcome pack. Someone who had recently been admitted to the ward expressed their view of having little knowledge of the purpose of the admission or plan. They did not know about their detention under the Mental Health Act and said they had not heard about independent advocacy.

Some people felt they did not have enough opportunity to get out of the ward, yet others enjoyed the walking group. One person was happy that they had been able to go out regularly with a relative and had “a nice trip home and also out to the hairdresser.” They added that the ward visiting hours were very flexible.

Two people wanted to tell us they had been in hospital for many months and felt “fed up.” One of them did not appear to have knowledge of MDT meetings, saying they weren’t offered. They added that they felt that their consultant psychiatrist didn’t care about them and never came to see them. Others spoke of how helpful they found their psychiatrist and how they had taken time to explain everything in a very detailed way.

We also heard that input from occupational therapy and physiotherapy had been beneficial to one individual who had been admitted to hospital using a wheelchair but had now progressed to mobilising with a walking stick.

Activities were offered but not everyone wished to participate, with some people saying they preferred to spend time in their own room where it was quieter. Musical bingo seemed to be popular with those we spoke to. One person said that activities were “enough but could be better.”

We were able to meet some relatives and one described staff as “brilliant and nothing is too much trouble” adding “they do nothing without telling me.” Communication was considered good, and they were kept informed, which included phone calls from the consultant psychiatrist. We heard that there did appear to be more staff on duty and that this was probably because of our visit, as ordinarily there would be four or five. The overall feedback we had was that there was enough activity to stimulate people, but it would be better if there was increased access to outdoor activity.

Visiting time was described as flexible out with mealtimes, but we heard that the ward could be “stifling hot” at times due to windows being unable to open. Relatives felt that this was not healthy for individuals nor staff.

## Care, treatment, support, and participation

Individual care records were documented in the electronic information management system ‘Care Partner’ that is in place across NHS Forth Valley. This system was used by all professionals involved in care and treatment delivery and we found it relatively easy to navigate.

Care records were updated regularly and included analysis of clinical presentations, information from family/carers and updates from activity co-ordinators.

Activity provision was documented in detail, including the level of engagement and any associated therapeutic benefits. Functional assessments, physiotherapy and engagement in psychological interventions, such as decider skills were available.

Some individuals participated in weekly review meetings but one person we spoke to was not aware of them happening, or of their care plan. They told us that otherwise, they felt informed about their care and treatment "people have been in to see me, it's been great."; they were aware of being referred for psychological therapy.

We could see involvement from a range of professionals including psychology, mental health officers, nursing, OT and psychiatry. The records evidenced that individuals' and families' views had been sought.

The care plans covered a range of physical and mental health needs. We found that the majority were reviewed regularly with individuals, but we noted that they would have benefitted from more detail, particularly around stress and distress behaviours. For one care plan we were unable to get a sense of the individual's participation in formulating the care goals and there was some paternalistic language used. This person was subject to the care programme approach (CPA) and it was recorded that a meeting had taken place however, we were unable to locate the minutes and could not see a date when the next meeting was due.

We found an example where one person had refused to sign the care plan or participate in MDT meetings. This was clearly documented and included information about the family's awareness of it and their status as proxy decision makers. We also saw that one-to-one interactions were frequent and recorded in the records, although one individual told us that he could not recall having any. Another individual was unclear about their care plan but their relative had a clear understanding of the aims of the admission, the treatment plan, and knowledge of the upcoming mental health tribunal.

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.

Physical health monitoring was good with regular reviewing, advice, and support offered to manage physical health concerns. Referrals to specialist services were made where required, such as physiotherapy, for those with falls risks and other ongoing needs. Documentation in relation to health monitoring was up to date and 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms and incapacity forms authorising medical care were completed following consultation with proxies and families.

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

Risk assessments were completed using the functional analysis of care environments (FACE) tool. We were told by managers that the MDT discussed risk at each MDT meeting and were currently reviewing risk assessments, although this was a large project where they were seeking wider agreement to take a more narrative approach to documented risks.

We were pleased to note that fortnightly community meetings continued, giving people a collective opportunity to discuss any issues pertinent to them. A positive development from this was the provision of ‘know your meds’ weekly drop-in sessions with the ward pharmacist. Information was shared with individuals helping them to increase their knowledge and understanding about pharmacological treatments, including possible side effects.

### Multidisciplinary team (MDT)

The ward MDT consisted of a broad range of professionals including nursing, pharmacy, OT, psychology, psychiatry, activity co-ordinators, physiotherapy and social work. Referrals could be made to other disciplines including dietetics and speech and language therapy as needed.

MDT meetings continued to happen weekly with detailed records of who attended meetings and clear action points relating to care plans and risk assessments. We also found that individuals and/or their family were invited to attend meetings, with their views noted in the meeting record.

## Use of mental health and incapacity legislation

Individuals detained under the Mental Health Act were aware of their rights, had access to legal advice and independent advocacy. Mental Health Act documentation was in place and available, with the legal status accurately recorded.

Any person 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 information relating to this.

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. One consent to treatment certificate (T2) did not cover all medications prescribed and the use of an ‘as required’ intramuscular medication was also included. Our view is that an individual is very unlikely to be consenting to IM medication for agitation at the time when this is felt to be urgently necessary. We would advise that best practice would be for this be authorised by a second opinion doctor as noted on pages 22 and 23 of our Medical treatment under Part 16 of the Mental Health Act good practice guidance.

We also noted for another individual that one medication had been prescribed, however, it was not authorised on the corresponding authorisation certificate (T3).

**Recommendation 1:**
Managers should ensure that all psychotropic medication given under Part 16 of the Mental Health Act is legally authorised and the consent forms used by the responsible medical officer to record consent should also detail all the treatment being consented to.

We were concerned about the robustness of the system currently in use to audit this. We were told that pharmacy audited Part 16 medication on a quarterly basis and the pharmacist endeavoured to attend the weekly MDT meeting. However, this was not always possible due to some staffing issues and providing cover for other areas in mental health services. Where more urgent action was needed, this could be highlighted by the pharmacy technician out with the meeting. The Commission advises that frequent audits could reduce the risk of discrepancy, leading to fewer, to no instances of medication being given out with legal authority.

**Recommendation 2:**
Managers must identify a robust system of auditing treatment forms to ensure that all treatment is authorised for detained individuals in accordance with conditions set out in the Mental Health Act.

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 (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. Documentation relating to the AWI Act, including certificates around capacity to consent to treatment were available.

For people we met with and/or reviewed who were subject to the AWI Act, we saw that care records had clear and accessible information about guardianship or power of attorney powers in relation to welfare and financial decisions.

## 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 person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

On the day of our visit, one person was specified under the Mental Health Act. The required documentation was completed, including a reasoned opinion which seemed reasonable and proportionate to the associated risk.

When we are reviewing individuals' 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 about treatments they want or do not want. We acknowledge that it can be difficult for individuals to write advance statements when acutely unwell, but it is important to discuss these throughout the admission as mental health and capacity improves. This may help to increase participation and understanding about treatment. Health boards have a responsibility for promoting advance statements. We are aware that Forth Valley Mental Health Act administrators write to individuals about this right on admission to the ward and it is also discussed in MDT meetings. Where advance statements had been completed, this was clearly documented in care records.

We spoke to individuals about accessing individual advocacy services and most people were aware of this, some of whom were already receiving support. We had previously spoken with a representative from Forth Valley advocacy who described links with the ward as positive.

The ward operated an open-door policy for those not subject to detention under the Mental Health Act. One individual admitted to the ward on an informal basis had spoken to us about not being allowed to go out unaccompanied. Nursing staff had discussed some safety concerns that they had agreed with, confirming they felt safer on the ward. There appeared to be some uncertainty about their current view on this, so we raised this with the DSCN. They advised there had been some consideration of whether detention was needed, and this was due to be reviewed that day on account of this.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

## Activity and occupation

On our visit, we spoke to individuals about activity provision. We were told about arts and walking groups, chess, other board games, pet therapy, access to the physiotherapy gym shared with Ward 4, a gardening group which maintained aspects of the ward garden, in addition to maintenance by the contractor.

One person said they had no interest on what was being offered and would like to have access to their own musical instruments on the ward as they felt they were getting out of practice due to their admission. We took the opportunity to observe seven individuals enjoying the body bingo group. They were singing along to the music and smiling as they exercised and listened to advice about keeping mobile at

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

home. We found evidence of activity participation recorded throughout the records with an emphasis on activities being tailored to the individual.

## The physical environment

Although the ward was bright and welcoming, we found the size of the lounge and dining room to be limited for the number of people using these areas. We were told it could be very noisy and given that less than half of the bedrooms had televisions, for many, this was the only accessible area. The provision of noise reduction panels was being explored for busier areas.

Individuals could access the garden area from the ward. There was a room designated for therapeutic activities and the addition of a recently created relatives room called the retreat, which was a positive development. The laundry and separate therapy kitchen were used for assessing functional ability. Some staff spoke about their hope that the environment could be improved with alterations, which would reduce the need for individuals in Ward 5 to have to access facilities in the adjoining ward.

All the single bedrooms had ensuite shower facilities and could be made more homely with personal effects. Each bedroom door provided information identifying the occupant, the nursing team allocated and their consultant psychiatrist.

Some individuals and staff told us how uncomfortable the environment was due to the windows being locked and air conditioning not working. This was discussed with managers who advised windows were required to be locked due to the ligature risk they posed. Anti-ligature work had been agreed, and this additional issue had been added to other essential modifications scheduled over the longer term. This programme of works was due to commence later in the year and temporary solutions such as film on windows to reflect heat was being sourced. Managers were also consulting with infection control colleagues regarding ventilation.

## Any other comments

The environment appeared to be the main issue for many individuals. We heard that it could be too hot during the day and because the under-floor heating had been turned off to manage the situation, it could then be too cold at night. The lack of ventilation in the rooms was also highlighted. We will continue to seek updates on the progression of the planned improvement work.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure that all psychotropic medication given under Part 16 of the Mental Health Act is legally authorised and the consent forms used by the responsible medical officer to record consent should also detail all the treatment being consented to.

**Recommendation 2:**
Managers must identify a robust system of auditing treatment forms to ensure that all treatment is authorised for detained individuals in accordance with conditions set out in the Mental Health Act.

## 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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