Mental Welfare Commission for Scotland

Report on an announced visit to:
Forth Valley Royal Hospital, Ward 1, Stirling Road, Larbert, FK5 4WR

Date of visit: 23 September 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 1 is a six-bedded intensive psychiatric care unit (IPCU) in the mental health unit at Forth Valley Royal Hospital in Falkirk. It provides assessment, care and treatment for individuals from the NHS Forth Valley catchment area who present with a higher clinical risk and who require more intensive treatment and intervention.

Accounting for this, IPCU units have fewer beds than acute assessment wards and are locked. IPCU wards also admit individuals diverted from court to hospital for assessment, where there are concerns that offending behaviour is linked to mental illness.

We last visited this service in November 2024 on an unannounced visit and made recommendations about individuals' participation in care plans, advance statements, specified person documentation and authorisation of psychotropic medication.

The response received was that weekly auditing of care plans would ensure that one-to-one meetings would include discussion and documentation to capture individuals' views. Advance statements would be considered and honoured where clinically possible and when not, individuals would be informed in writing of the reasons for this. To ensure compliance with specified person legislation, the multidisciplinary team (MDT) would discuss restrictions and interventions in the weekly meeting. This information will also be included in the handover discussion template, and a flow chart made available to increase staff knowledge and awareness of this. Medication consent and authorisation would also be reviewed at the MDT meeting, checking that current prescribed medication corresponded with consent and authorisation.

Who we met with

Prior to our visit, we had a virtual meeting with the senior charge nurse (SCN) and the clinical nurse manager (CNM).

We spoke with staff during the visit as well as the service manager (SM), the clinical director (CD), the associate medical director (AMD), one of the responsible medical officers (RMO), the chief nurse for mental health and learning disability, the SCN and the CNM, who all attended the feedback meeting at the end of the day.

On the day of our visit there were five individuals on the ward however, one of them was discharged home that morning. Three people agreed to speak with us, one of whom was a relative and we reviewed the electronic care records of four people. We also met a Forth Valley advocacy representative visiting the ward.

Commission visitors

Denise McLellan, nursing officer

Tracey Ferguson, social work officer

What people told us and what we found

One individual told us that the ward was “good”, and they were happy with the privacy their single, en-suite room gave them. The standard of meals was also rated as “good” and we were told that “staff are really nice and always available.”

For individuals, having access to the garden was important due to being confined to the ward. When it became dark, access was restricted due to a lack of lighting. New lights had recently been fitted but unfortunately had to be removed as they were found to pose a ligature risk. The heat and lack of air flow was commented on, with people finding this a problem due to the windows being locked. We discussed this with senior managers who told us that funding had been granted for a long-term programme of works and replacement lighting was being sourced.

An individual told us that on admission, they did not have clothing or personal effects, but their RMO travelled to collect them which was very much appreciated and helped to make the admission more comfortable for them.

Another person provided similar feedback about the environment lacking air flow because the windows did not open. Although they did not believe it was necessary to be detained in hospital and were unhappy about this, they generally found staff “nice and approachable.” They also liked having an en-suite bedroom. They commented that although activities were in place, they did not always happen. They were also unhappy that they were not permitted to smoke in the garden and were planning to ask about increased time off the ward in addition to what they already had.

The relative who spoke with us was positive about the care and treatment that was being delivered in Ward 1. They informed us of their long involvement with mental health services from the perspective of being a relative/carer. They fulfilled the named person role, attended meetings and regarded themselves as being an active and informed participant in the treatment planning. “I see myself as part of the team in a way.” They spoke of being “full of admiration for the entire team” and how they were “superb, a big support” but also singled out some individuals for additional praise. The RMO was described as “excellent, sees the bigger picture and the best mental health specialist since 2011” that their relative had had.

The relative gave an account of a complex situation where in addition to their family member’s mental health being treated, they had required specialist medical input in a different health board area. The complexity of the situation was explained to the relative along with being asked for their thoughts on how a good level of communication between medical and nursing teams ensured the success of the procedure, from planning, transfer and follow up. The relative commended the SCN as head of the nursing team for being “excellent.” The mental health officer (MHO) was also regarded highly “they are very good; they communicate a lot.”

Care, treatment, support, and participation

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

Entries on the system were detailed and included admission assessments, input from liaison, medical reviews, pharmacy reviews, physical health investigations, input from other specialist medical staff and health monitoring associated with psychotropic medication. There was ongoing contact with the MHO.

Continuation notes regarding daily presentation that were completed by nursing staff provided a good description of mental health symptoms and engagement. One-to-one meetings were regular and individuals' views were clearly recorded.

Occupational therapy (OT) notes gave accounts of individuals' skill levels as well as their views and conversation that arose when participating in groups. Functional assessments by OT were being completed for travel and bus pass application.

Care plans covered a range of physical, mental health and wellbeing needs. Interventions to meet goals were detailed and the care plans were strengths-based. Although one had not been signed, it was evident from reading it that the individual's views had been recorded, including a discussion about rights. We saw one example where language such as "hostile and argumentative" was used which was not in keeping with a recovery-focussed approach.

Risk assessments were completed using the functional analysis of care environments (FACE) tool. We found these to be informative and regularly reviewed. There was an example where consideration of risk was balanced alongside personal needs with rights being protected. We discussed with the SCN how this was managed in the setting and we found this to be a dynamic process.

Individuals participated in weekly meetings along with relatives/carers. The weekly MDT meeting records were comprehensive, and the template provided information about attendees, nursing updates, rights and restrictions where applicable, the treatment plan and actions to be taken along with individuals and relatives' views being sought and documented.

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.

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

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 as needed.

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

Use of mental health and incapacity legislation

During our visit, there were four people in the ward, three who were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). One person was subject to section 52D of the Criminal Procedure (Scotland) Act, 1995 (the Criminal Procedure Act). This person had been diverted from court for an assessment of their mental health and treatment if required.

Individuals detained under the Mental Health Act had been provided with information about their rights, their order and upcoming mental health tribunal. The person subject to the Criminal Procedure Act was aware of the reason for diversion and that a report would be submitted to the court. All legal documentation was in place and easy to locate on Care Partner.

Any person receiving 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.

Legal advice and independent advocacy were being accessed. Details of the local advocacy group were displayed, and we heard there was a good level of advocacy support to the ward. We were told that referrals could be made via phone call, online or email and the service was responsive.

Advocacy supported individuals to make named person nominations and inform them about making an advance statement. 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. We are aware that the hospital’s 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 made, we found these easy to locate in the records.

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. We found one occasion where an 'as required' anxiolytic had been prescribed but had not been authorised on the corresponding T3 certificate. This was highlighted at the feedback meeting and the RMO agreed to rectify this.

Recommendation 1:
Managers should ensure that all psychotropic medication given under Part 16 of the Mental Health Act is legally authorised and an audit system put in place to monitor compliance.

Rights and restrictions

The door to the IPCU was locked, commensurate with the level of risk and level of clinical acuity on the ward.

Time off the ward was regularly reviewed and people were aware they could discuss this with the team if appropriate to the legislation they were detained under. We saw evidence of MDT discussion reviewing the need for individuals to continue receiving treatment in this restrictive environment, with plans to transfer them to open wards being made.

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 two people were specified. The corresponding forms that authorised the restrictions were in place and the reasoned opinions were documented and explained the requirement for the restrictions. We noted that one care plan incorrectly stated an individual was specified for phone use, but this was no longer the case; we highlighted this to the SCN.

The Commission has produced good practice guidance on specified persons[2].

The Commission has developed *Rights in Mind.*[3] 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.

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

On our visit we spoke to individuals about activities available. There was no activity co-ordinator allocated to the ward; however, there was input from co-ordinators who worked across the three adult admission wards.

An activity planner was in place and had information about the breakfast club, relaxation sessions, the coffee morning, a newspaper group, boxing with physiotherapy, therapet visiting and a gardening group. People had access to a gym in the ward and there was also a pool table, board games and games console.

We had been told that people enjoyed visiting the garden where they could listen to music. One person said that being able to spend time in their room allowed them to practice on a musical instrument for relaxation and enjoyment. The SCN informed us of plans being made for a social enterprise group for individuals to make small Christmas items that could then be sold in the main hospital atrium. Funds would be used for other activity provision. We look forward to hearing about their success in this venture.

The physical environment

There was sufficient space in the ward with a separate dining room, lounge area, and several small interview meeting rooms. The addition of a sensory room had been introduced and the SCN spoke of her hopes to develop this further to make the ward a more tranquil and welcoming environment.

All the single bedrooms had ensuite shower facilities and there was a large bathroom with a bathtub available. Some of the rooms had evidence of mould around ceilings. All windows in the rooms were locked due to being a ligature risk, which led to a lack of ventilation. Managers told us that a programme of works to replace these older windows 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.

There was access to an enclosed garden from the main sitting area. It was well maintained, but it is no longer lit. Managers were awaiting suitable replacements to be able to have lights in this area.

Any other comments

We heard that pressure continues to be experienced with staffing issues, including the need for redeployment and bank staff use, along with the other wards in the mental health unit.

We heard that it was a supportive environment and that staff wanted to work there but there were concerns expressed about the longer-term impact on care delivery and levels of satisfaction. Due to the unpredictable nature of the environment, higher

levels of acuity and the subsequent need for additional staffing for continuous interventions, this could result in further pressure and having to continually prioritise and postpone tasks.

We are aware that this can lead to staff feeling frustrated at being unable to complete all the functions of their roles in the way they would wish. We were told that over-recruitment has been authorised to help alleviate this problem. The SCN made themselves available throughout the visit, but we became aware that they were also fulfilling additional responsibilities of coordinating other wards in the mental health unit due to other absences on the day.

We were pleased to see that all wards in the mental health unit were now supporting individuals to observe legislation about not smoking in hospitals. The World Health Organisation's 'World No Tobacco Day' on 31 May 2025 had been selected as the launch date for a successful MDT approach which promoted the health benefits of stopping smoking through education, therapeutic activity and the availability of smoking cessation products.

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 an audit system put in place to monitor compliance.

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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