Mental Welfare Commission for Scotland

Report on unannounced visit to: Forth Valley Royal Hospital, Wards 2 and 3, Stirling Road, Larbert, FK5 4WR

Date of visit: 11 October 2018

Where we visited

Ward 2 comprises 18 bedrooms, nine of which are en suite, and is designated as an adult acute admissions ward for both male and female patients. The ward admits patients from the Stirling and Clackmannanshire areas with care managed by two consultant psychiatrists. The ward also admits adults for planned detoxification from alcohol and people who need help with an eating disorder. On the day of our visit there were 17 patients on the ward.

Ward 3 comprises 24 bedrooms, nine of which have en-suite facilities, and is designated as an acute adult admissions ward for both male and female patients. The ward takes admissions from the Falkirk area with care managed by four consultant psychiatrists. The ward also admits women for assessment in the perinatal period. On the day of our visit there were 18 patients, including three who were boarding in from Ward 2.

We last visited this service on 17 October 2017 and made recommendations in relation to the need for more person-centred care plans, occupational therapy (OT) input to the wards, the provision of a more comfortable and therapeutic environment, and additional support for adults experiencing their first episode of illness.

This was an unannounced visit and during this visit we wanted to follow up on the previous recommendations and also look at some issues which have been raised with the Mental Welfare Commission (the Commission) over the year in relation to communication, visiting arrangements, interaction with carers, and restrictions on accessing and leaving the ward for informal patients. This is because the Commission had received calls and written correspondence about these topics and had been asked by these correspondents to look into their experiences within the wards.

Who we met with

We met with and/or reviewed the care and treatment of 12 patients. We did not meet with any relatives/carers on the day.

We spoke with the clinical nurse manager and the senior charges nurses for both wards.

Commission visitors

Yvonne Bennett, Social Work Officer

Michael Diamond, Executive Director (Social Work)

Mary Leroy, Nursing Officer

Ritchie Scott, Medical Officer

What people told us and what we found

Care, treatment, support and participation

Following the recommendation in relation to care planning from last year's visit, we wanted to review patient care plans to see how the actions taken by the service had translated into improvements in the quality of these plans. We heard that following this recommendation a baseline audit had been carried out which highlighted areas of required improvement, and that teaching around person-centred care planning was provided on an ongoing basis by senior nursing staff. In addition we heard that this would be reviewed regularly within individual staff supervision sessions.

What we saw within patient records was that while there was evidence of improvement, there was still work to be done to address the quality of written care plans. While we saw good examples of person-centred, outcome-focussed planning, we also reviewed files where care planning was minimal, lacking detail pertinent to the individual and little evidence of patient/carer involvement in these processes. In addition we saw language within patient files which was pejorative, and highlighted this on the day to senior nursing staff.

Overall, we recognised the activity which had been carried out in terms of care planning improvement but this remains a work in progress, particularly in relation to patient/carer involvement. We heard how the service was planning on purchasing handheld tablet computers which would allow staff to engage and record care plans in real time and which would support patient involvement and we look forward to seeing how this initiative develops.

We heard that multidisciplinary team (MDT) meetings are convened weekly for all patients and that the format of recording these meetings had recently changed. The recording template is comprehensive and, if fully completed, provides a good overview of baseline assessment, progress, risk, and discharge planning. There was, however, considerable variation in the level of MDT recording within patient records we saw, again particularly in relation to patient and family perspective and involvement.

We received a number of calls and letters from patients and carers highlighting issues in relation to communication within the wards between patients and staff, and carers and staff.

During our visit we wanted to seek the views of patients in relation to who their named nurse was and what interactions they had with their named nurse. The named nurse role is important in ensuring that a patient's needs are met, services are co-ordinated, and as a mechanism for establishing a therapeutic alliance with the patient.

Very few of the patients we saw on the day knew who their named nurse was and notice boards within patient bedrooms which were designed to display key information, including details of the named nurse, were left blank.

In discussion with senior nursing staff, this was an area which they had already identified as requiring improvement and staff within Ward 3 were piloting improvement in observation practice, ensuring observations were interactive, and were also actively considering ways to improve the named nurse system to ensure that nurses were proactively promoting this role both with patients and families as a means of improving care and communication.

Recommendation 1:

Managers should audit and improve the quality and content of patient care plans to ensure they are person-centred, recovery-focussed and involve patients, and where appropriate, carers and families.

Recommendation 2:

Managers should audit current named nurse process for ongoing improvement activity.

Use of mental health and incapacity legislation

Of the 35 in patients on the day of our visit, 20 were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA).

We reviewed records for 12 of those patients and found appropriate documentation which authorised their care and treatment within the ward. We reviewed consent to treatment documentation which was recorded on the Hospital Electronic Prescribing and Medicines Administration (HEPMa) electronic system and found that these contained some discrepancies between what was recorded on the consent to treatment certificate (T2) and what was being administered. In two instances T2 certificates were not available on record, although we saw from our records that they had been completed.

We saw within patient files when ‘as required’ medication had been administered. These notifications included a review of the effectiveness of this medication but in a significant number of these notifications, this review was not completed.

Section 281 to 286 of the MHA provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the MHA, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

We looked at documentation for specified persons under the MHA and found this also required some review, as there was a discrepancy between paperwork recorded in the paper file and the patient status on the electronic record on Care Partner.

We had heard on our last visit that the service was preparing to go 'paperlite' in November 2017. This had not yet happened and the service continued to work across paper case notes and electronic recording, and we speculated that this could result in these identified discrepancies.

A number of patients were subject to provisions of the Adults with Incapacity (Scotland) Act 2000 (AWI) and we saw copies of appropriate documentation within the paper files, including section 47 certificates of incapacity, authorising medical treatment for adults who lacked capacity to consent to this treatment.

Recommendation 3:

Managers should carry out an audit of legal documentation to ensure this is current and recorded accurately across both paper files and electronic systems.

Recommendation 4:

Managers should carry out an audit of consent to treatment certificates (T2) to ensure they remain current and correlate with medication being administered.

Rights and restrictions

Both wards operated a locked door policy, and access and egress to and from the ward is monitored by a staff member seated at the door noting who was coming and going from the ward, their expected time of return, and what they were wearing at the time of exiting the ward. We understand that this practice is part of the way that the service maintains safe practice. However, this practice had been the subject of considerable interest from patients and visitors who had contacted the Commission.

In particular informal patients have told us that they feel this is overly restrictive as staff note when they leaving and returning, and what they are wearing. Visitors too spoke of how these arrangements did not offer any privacy as they heard who was visiting as well as patients' names. Due to the levels of activity in this area, visitors reported that there was often a queue of people waiting to be processed through this system so that a range of people could hear details of both visitors and patients.

We discussed this in previous visits and there was a view that this was the only means by which patient safety could be maintained, and in fact was established in response to findings from a local Significant Adverse Event Review. In discussion with senior staff we heard how there are discussions ongoing about how this could be managed more confidentially and formal reception area might be a potential solution to this issue. As an interim measure we suggested looking at how other areas acute mental health services manage this area might offer more immediate options.

We also noted during the last visit that visitors were encouraged to conduct visits within the small interview rooms rather than visiting with the main ward areas. We heard that

access was now available to the dining room area for visitors, and that visitors in some circumstances visit within the ward, and we welcomed these additional options.

During the visit we discussed the number of patients who were not subject to mental health legislation and were restricted in their time off the ward. We were assured that this was with the patient's agreement in individual cases and that patients were informed of their rights routinely.

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. We suggested that this document could be used in community meetings which have recently started within both wards, as discussion material to ensure patients are aware of their rights, particularly in relation to time off the ward.

This pathway can be found at https://www.mwcscot.org.uk/rights-in-mind/

Recommendation 5:

Managers should look at alternative means by which to manage access to and from the ward until a reception area is in place.

Activity and occupation

Since our last visit three activity co-ordinator posts had been created and recruited to. This had supported the development of a structured activity programme within the wards and ensured that activities go ahead regardless of clinical demand within the ward. We saw records of patient engagement in planned activities and conversely if there was no engagement by a particular patient we saw reasons for this and evidence of continued attempts to encourage engagement.

We saw a full programme of activities available throughout the week which included health promotion, activities of daily living, therapeutic activity, art, mindfulness, and Therapet.

Occupational therapy (OT) cover within the ward had improved since our last visit with dedicated OT involvement in each of the wards. This activity is assessment focussed, we saw evidence of this within patient files.

Two activities which we heard about from the patients we spoke to were the safety and stabilisation group and the daily community meeting. Patients spoke positively of both of these activities.

The physical environment

On our last visit we made a recommendation that priority should be given to providing a more comfortable therapeutic environment. We were pleased to see significant improvements to the environment, with more casual lounge furniture available in

communal areas, colourful artwork on the walls, and soft furnishings which together made for a more homely and comfortable space.

We heard of plans to convert current office space into bedrooms so that patients' living areas would have more natural light (the current bedroom area is dark and artificially lit) and offer more opportunity for patient observation. We would support this plan as a significant improvement to the service.

Any other comments

Since our last visit the wards had been operating with a number of vacancies and as a result there had been a reliance on bank staff, which had impacted on the ongoing practice development within the service. During the visit we heard that all vacancies had now been filled and induction training is underway for all new staff. Senior nursing staff report that this will allow the service to develop and provide a more consistent quality of service.

Overall we felt that the issues we raised on behalf of patients and carers were already recognised by senior nursing staff. We saw improvement activity designed to address these issues change some areas of practice and culture within the wards, most notably increasing staff presence and engagement with patients and reducing staff time spent within the office. We look forward to seeing how this develops.

As part of a commitment to continuous improvement we heard that the service is in the process of preparing to sign up to the Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services (AIMS). AIMS is a standards based programme designed to improve the quality of care in inpatient mental health wards. The process takes the service through a comprehensive review of the services they provide, highlighting good practice and providing support to achieve high standards of care.

Summary of recommendations

1. Managers should continue to audit and improve the quality and content of patient care plans to ensure they are person-centred, recovery-focussed and involve patients and where appropriate, carers and families.

2. Managers should audit current named nurse process for ongoing improvement activity.

3. Managers should carry out an audit of legal documentation to ensure this is current and recorded accurately across both paper files and electronic systems.

4. Managers should carry out an audit of consent to treatment certificates (T2) to ensure they remain current and correlate with medication being administered.

5. Managers should look at alternative means by which to manage access to and from the ward until a reception area is in place.

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

Mike Diamond, Executive Director (Social Work)

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 MWC 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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