Mental Welfare Commission for Scotland

Report on announced visit to: Hope House, Bellsdyke Hospital, Bellsdyke Road, Larbert FK5 4SF

Date of visit: 31 January 2018

Where we visited

Hope (Dochas) House, is a six-bedded unit within the community village of Bellsdyke Hospital. The unit provides treatment, support and rehabilitation for women with more complex mental health care needs, who require greater levels of support and supervision.

This is a new facility which opened in August 2017 with planned admissions of patients on a gradual basis, reaching full occupancy by October 2017.

Although the service is still in its infancy we wanted to visit to view the facility and to hear about the model of care the unit provides. This will also provide a baseline to measure development and progress of the service at future visits.

Who we met with

We met with and/or reviewed the care and treatment of four patients and spoke with one carer after the visit.

We spoke with the senior charge nurse, the clinical nurse manager, the consultant psychiatrist and responsible medical officer for all six patients and the clinical psychologist that covers Hope House.

Commission visitors

Yvonne Bennett, Social Work Officer

Margo Fyfe, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The preparation time prior to the opening of this unit has afforded the staff team a fairly unique opportunity to consider the model and ethos of service provision within Hope House. We heard about the comprehensive training and development process that the staff undertook to create the therapeutic environment which would offer patients the best opportunities to progress their recovery. It was recognised that patients coming to the unit have all had lengthy experiences of inpatient psychiatric care and we heard that the care team wanted Hope House to offer care in a different way, recognising the patient journeys to date.

Staff were trained in trauma informed interventions, safety and stabilisation, management of deliberate self-harm and have been involved in development work around positive risk taking, self-management and recovery.

The unit operates a home style model, where staff and patients prepare, cook and eat together. Patients are also responsible for their own laundry and domestic chores

within the unit. This model of care was welcomed unanimously by the patients we spoke to who felt they had more control over their environment and choice about what they wanted to eat. One patient told us that it ‘makes me feel normal - having to do laundry, think about what we want to eat and go to the shops to buy what we need’. We heard that access to kitchen and domestic appliances did present challenges in terms of risk but that the benefits of this model greatly outweighed the negatives and were subject to rigorous individual risk assessment and management plans.

Care plans we reviewed were detailed, person-centred and evidenced regular reviews and change according to need. Similarly the nursing notes were detailed and involved patients. Within the electronic case records, we saw evidence of patients signing off and agreeing their care plans. We heard that there are plans to equip the unit with hand held computers so that patient records can be compiled directly with patients. Therefore, they are fully aware of what is being recorded and can contribute to this record in real time. We suggested, as an interim measure, the service might consider printing off care plans to be retained by patients who can then refer to and consider them out with formal sessions.

We heard that multidisciplinary team meetings (MDTs) occur weekly with attendance from the full range of disciplines. Hope House has a dedicated psychologist and occupational therapist on a part time basis. The meetings are lengthy due to the complexities of the care being provided and as a result review each patient fortnightly. That being the case, we found the records of the MDTs lacked detail and the service agreed that they needed to consider the style and method of recording which will capture the depth of these discussions.

Use of mental health and incapacity legislation

All the patients within Hope House are subject to mental health legislation and treatment is duly authorised by either consent to treatment certificates (T2s) or certificates authorising treatment (T3s).

On the day of our visit, there was one patient who was designated a specified person and we saw evidence of a considered opinion for the need for this restriction and a timescale for early review.

All legal paperwork is current, readily accessible, scanned and evident within electronic files.

Rights and restrictions

Due to levels of risk within the unit, there are a range of restrictions in place, but in each instance of restriction, there was an up to date risk assessment and management plan which included early dates for review.

We heard about a significant reduction in the levels of enhanced observation for individual patients since their admission to Hope House. Also, we heard about preparation required, both for patients and staff, to consider a more proactive approach to positive risk taking which was assessed and evidenced as acceptable and in the patient's interests.

This approach was overwhelmingly welcomed by the patients we spoke to, albeit with some concerns expressed about how difficult at times this added responsibility could be.

Forth Valley Health Board operates a non-smoking policy, but within the unit there are allocated smoking times within a designated area of Hope House's gardens.

Activity and occupation

Within Hope House there is a daily meeting, which patients are encouraged to attend, where staff and patients allocate tasks and discuss any activities or appointments planned for the day. In addition, there is a weekly community meeting to consider the overall activity, the ethos of the unit, celebrate success and consider any developments or future planning.

This, plus the domestic activity, lays a basic structure for activity and in addition there are a range of activities either within the ward, on site or community based where appropriate and safe. These include Artlink, a community group who visit Hope House, gym attendance, both on site and with a women's group at a local facility and horticulture projects. In addition, there are group opportunities which are run within Hope House by nursing and occupational therapy staff which include mindfulness, safety and stabilisation, behavioural activation and trauma informed sessions.

The unit are currently considering the addition of an activity coordinator. This post will enhance links to community groups and projects, which will develop the potential for a more seamless return to community living at an appropriate stage in their recovery.

The physical environment

The unit is a bright, clean environment which has recently been refurbished to accommodate this service. On the day of our visit it was very quiet and calm. The living areas and activity areas are separate, and there is access to a secure garden space. This space requires significant development to improve its appearance and functionality and there are plans for this to progress with the involvement of the patients.

During our discussions with patients and carers, there was a view that there should be emergency call systems available within the bedrooms due to the high levels of

risk being managed within the unit. This was fed back to staff for further consideration.

In addition, there was a view expressed by carers that the unit would have benefitted from en-suite toilet/bathroom facilities and that this is seen as standard in any new facility.

Any other comments

Physical care needs featured in a number of discussions with patients. We heard that the unit is covered by a local GP practice during office hours and by NHS 24 out with these times. Patient feedback in relation to this cover was poor, with a view that this service did not always meet their needs; that self-harm was not understood and treatment was therefore not always appropriate.

We heard a specific example of a patient having sustained an injury and we have asked the service to conduct an internal review of this incident.

We discussed the process by which staff reach a decision about seeking additional medical intervention following an incident of self-harm and what guidance is available. It was agreed that this was an area for further development.

In addition, this should also include establishing and developing links between Hope House and the emergency department to ensure an understanding of self-harm and an appropriate and timeous response, when required.

Recommendation 1:

Managers should consider a protocol for assessment of the need for further medical intervention following an incident of deliberate self-harm.

Recommendation 2:

Managers should review the provision of GP services within the unit to ensure it meets patient needs.

Recommendation 3:

Activity to establish a patient pathway between Hope House and the emergency department within Forth Valley Royal Hospital should be progressed as a matter of urgency.

Good practice

Hope House offers an innovative response to the needs of women with complex mental health presentations. The development of the model of care to date has been collaborative and has involved patients in a meaningful and structured way. The ethos of positive risk taking, informed by comprehensive risk assessment and

management plan has supported patients to progress, even within the short period of time the unit has been operating.

Summary of recommendations

1. Managers should consider a protocol for assessment of the need for further medical intervention following an incident of deliberate self-harm.

2. Managers should review the provision of GP services within the unit to ensure it meets patient needs.

3. Activity to establish a patient pathway between Hope House and the emergency department within Forth Valley Royal Hospital should be progressed as a matter of urgency.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

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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