



Mental Welfare Commission for Scotland

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

Date of visit: 25 October 2017

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 takes admissions from the Stirling and Clackmannanshire area, with care managed by two consultant psychiatrists. The ward also admits people for planned detoxification from alcohol. On the day of our visit there were 16 patients on the ward.

Ward 3 comprises 24 bedrooms, nine of which are en suite, and is designated as an adult acute 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, and young people under the age of 18. On the day of this visit there were 20 patients on the ward.

We last visited this service on 5 and 7 May 2015 respectively and made recommendations in relation to specified persons, recording of suspension of detention, care plans, consent to treatment and the environment.

On the day of this visit we wanted to follow up on the previous recommendations and also look at activities available to patients, information provided to patients on admission and the inclusion of relatives/carers.

Who we met with

We met with and/or reviewed the care and treatment of 15 patients and met with one relative.

We spoke with the senior charge nurses from both wards and the clinical nurse manager.

Commission visitors

Yvonne Bennett, Social Work Officer and visit co-ordinator

Margo Fyfe, Nursing Officer

Kathleen Taylor, Engagement and Participation Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Nursing Care Plans

We heard, following the last visit in 2015, that recording was changing from the FACE system to Care Partners system which would allow more patient-centred documentation and a more patient-friendly care plan. The new system offered the opportunity to use free text which could refine the more generic care plans with richer person-centred information. On this visit we did not see evidence of this improvement and the care plans we saw remained generic, lacked detail pertinent to the individual patient and their recovery, and evidence of patient involvement.

Recommendation 1:

Managers should carry out an audit of care plans and ensure that care plans are put in place which are person-centred, meaningful, involve the patient and carer where appropriate, and are outcome focussed.

Multi-Disciplinary Team meetings

We heard that across the two wards there were six consultants, each of whom held a multidisciplinary meeting (MDT) each week, and that the frequency of these meetings impacted on the availability of nursing staff.

Due to a number of changes in consultant psychiatrists over the last six months, there was a recognition that consultant cover varied over the last few months, which may have impacted on the continuity of patient care.

In response to this, we heard how the recording of MDTs was in the process of being reviewed to provide a more comprehensive record of who was involved in this process, a more detailed summary of nursing involvement, diagnosis, physical care, patient and family perspective and the outcome of the MDT. This is a welcome improvement and we look forward to reviewing this in terms of outcomes for the patient.

Use of mental health and incapacity legislation

On the day of our visit there were 12 patients who were subject to Mental Health (Care & Treatment) (Scotland) 2003 legislation. Of those detained patients we reviewed, legal documentation was available within the file. Consent to treatment documentation was recorded on HEPMa electronic system and there was evidence of pharmacy input both within this system and MDT records.

We heard that the service was planning to go 'paper light' from November this year and we will be interested in how this will improve recording within the wards, particularly with reference to legal documentation.

Rights and restrictions

There is a controlled entry system to and from the wards, with a staff member seated at the door noting access and egress of patients.

There is a policy that restricts visiting in the main ward areas. Visitors can utilise three small interview rooms in the corridor, with opportunities for the use of further two rooms' outwith times when they are required by the Mental Health Tribunal Service. This is laid out in the information booklet provided to patients on admission; the recorded rationale for this policy is to preserve confidentiality and allow patients a space to relax in. We felt that this was a restrictive policy, particularly when there was such limited space for visitors to use. We heard that there are ongoing negotiations aimed at utilising the dining room area outwith meal times for visits, and that this has been escalated further to senior management.

We expected this policy to feature in our discussions with patients during the visit, but feedback in relation to this was positive, with a view that this offered private space for patients and offered a degree of protection to relatives when patients are particularly unwell. We heard that there was a degree of flexibility within this policy and visitors could access the ward in exceptional circumstances.

Activity and occupation

Activities are available to patients seven days per week. These are facilitated by nursing staff, in the main. Senior nurses from both wards jointly plan events for the forthcoming week and allocate nursing staff to support the planned activities. This time is not dedicated and is dependent on clinical need. We heard that there is a commitment from senior nursing staff to ensure, where possible, activities are prioritised but that this is not always possible.

We heard that occupational therapy (OT) cover over the last few months has been significantly depleted due to staff sickness, and as a result there has been a reduction of group programmes within the wards. We heard that this has also impacted negatively on OT representation within MDTs and that OT input to the wards focussed on functional assessments and has been unable to contribute to the therapeutic activity within the ward.

We were pleased to hear evidence from patients that the weekly art therapy sessions were highly valued and well attended.

Recommendation 2:

Managers should review OT provision within the wards to ensure capacity for therapeutic activity.

The physical environment

The wards are situated in the Specialist Mental Health Unit within the grounds of Forth Valley Royal general hospital.

When we visited previously we recommended that managers ensured that priority was given to providing a more comfortable therapeutic environment for patients. We were disappointed to see that there have been minimal change made to the environment.

The day room and corridors remain clinical and stark, and there was little evidence that this issue had been addressed since the last visit. We heard that joint working between the clinical areas and the art strategy group have taken place, and that art work has been introduced to the clinical areas, and that more comfortable chairs are on order to improve the comfort and look of the day room. Further action in relation to developing a more comfortable environment is still required.

Recommendation 3:

Managers require to ensure that priority is given to providing a less clinical environment which is more comfortable and homely and conducive to recovery and well being for patient who require treatment for mental illness.

Any other comments

During our visit, we met with two patients who spoke about their first episode of illness and admission to the ward. Both spoke of feeling extremely anxious and unaware of what to expect during their admission, and of practices and language which they did not understand e.g. "time out". They also alluded to the feeling that other patients knew the 'routine', and they would have benefitted from some additional input on admission to make sense of what was happening for them.

Commission visitors witnessed a situation where staff stated they were too busy to attend to one of these individual's immediate need and distress, and this concerned us. We spoke to managers and charge nurses on the day but are keen to hear further what is being put in place to ensure this situation does not recur.

We saw a Patient Information leaflet which was helpful and informative, but could be supplemented by additional interaction from staff to support the patient to settle on first admission.

The Commission's Patients' Rights Care Pathway document is a useful resource which might be used as an improvement resource for services. We encourage staff to reflect on their policies and practice, and to use the guide and accompanying Rights in Mind booklet and videos as a resource for training and discussion, and to select areas to focus on for improvement. A link to this resource is provided below:

http://www.mwscot.org.uk/media/367147/rights_in_mind.pdf

Recommendation 4:

Managers should consider the management of admissions for patients who were experiencing their first episode of illness.

Summary of recommendations

1. Managers should carry out an audit of care plans and ensure that care plans are put in place which are person-centred, meaningful, involve the patient and carer where appropriate, and are outcome focussed. We would expect feedback on this recommendation within three months.
2. Managers should review OT provision within the wards to ensure capacity for therapeutic activity.
3. Managers require to ensure that priority is given to providing a more comfortable therapeutic environment.
4. Managers should consider the management of admissions for patients who were experiencing their first episode of illness.

Good practice

There was evidence of improved focus on physical care within the wards with the establishment of the National Early Warning Score (NEWS) charts, and robust medical examinations on admission. We also saw documentation which is currently being piloted as part of an Improvement Plan to ensure safe transfers between psychiatric services and acute medical and surgical ward.

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 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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777

e-mail: enquiries@mwscot.org.uk

website: www.mwscot.org.uk

