



**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Forth Valley Royal Hospital,  
Wards 4 and 5, Stirling Road, Larbert FK5 4WR

**Date of visit:** 5 December 2017

## **Where we visited**

Wards 4 and 5 are both 20-bed mixed sex old age psychiatric admission and assessment wards. Ward 4 provides care and treatment for individuals with a diagnosis of dementia, and ward 5 for patients with a functional illness and milder cognitive impairment. We heard that although this was the formal remit of each ward, there was a degree of flexibility for admission to either ward dependent on patient need.

We last visited this service on 5 January 2016 and made recommendations in relation to care planning, patient safety, the environment and consistency in recording.

On the day of this visit, we wanted to follow up on these previous recommendations.

## **Who we met with**

We met with and reviewed the care and treatment of 11 patients and met with three carers/relatives/friends.

We spoke with the charge nurses for both wards and a staff nurse, as well as the service manager and specialist dementia nurse.

## **Commission visitors**

Yvonne Bennett, Social Work Officer (visit coordinator)

Margo Fyfe, Nursing Officer

Paul Noyes, Social Work Officer

Ritchie Scott, Medical Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

In our previous report, we made recommendations related to improving the care plans to ensure they were more person centred and took account of all of the individuals' care needs. On this visit, we saw care plans which referred to the patient specifically by name, but still lacked detail around interventions, particularly where there were high levels of stress and distress. An example of this records that staff would use 'de-escalation techniques' in the event of stress/distress but lacks the detail about what this intervention might be for the individual. We heard that there has been significant training around stress and distress interventions and this could be reflected more within care planning activity. The daily nursing notes were detailed and provided a good record of the patient's presentation on a day-to-day basis.

We heard that the service is moving to a 'paperlite' style of record keeping and are considering the information they need to retain in paper form. In the meantime, there

is a fragmented style of recording with different disciplines using different methods of recording their intervention. This has resulted in information being stored across a number of paper and electronic files and we felt this could result in important information not being easily accessed or missed.

We heard from staff and carers that consultant psychiatrist cover has been provided in part on a locum basis over this year. This has led to some inconsistencies and in one instance we noted a significant impact on patient care. To address this, the service has implemented a protocol whereby patients with complex care needs are being managed by permanent consultants, regardless of catchment areas. This seemed to be a positive response to this issue.

We also heard that the service is piloting the use of a multidisciplinary team (MDT) recording tool on the Care Partner system to ensure that key decisions are clearly recorded and readily accessible.

The model of MDT is one where the multidisciplinary meeting considers the care plan for each patient, and key decisions are then relayed and explained to patients and carers. We would welcome more opportunity for patients, where possible, and carers to participate more fully in this decision making process.

There was significant involvement of a dementia nurse specialist within both wards. A dementia audit had been carried out within Ward 4 which has resulted in environmental improvements, training in the assessment and management of delirium, as well as the management of stress/distress pilot which is ongoing. There are plans to carry out a similar process within Ward 5.

#### **Recommendation 1:**

Managers should continue to develop person-centred care planning to include a more detailed description of intervention to alleviate distress for individual patients.

#### **Recommendation 2:**

Managers should ensure patient information is recorded in a consistent way across the MDT, and is easily accessible, either electronically or in paper form.

### **Use of mental health and incapacity legislation**

There was evidence of progress in appropriate authorisation for treatment which was a recommendation of the previous report. Within patient files we saw Adults with Incapacity (AWI) s47 certificates accompanied by treatment plans relevant to the individual. Consent to treatment certificate (T2) and certificate authorising treatment (T3) were also in place where required, with covert medication pathways in place where necessary.

There was evidence in one instance of the use of back-to-back short term detention certificates. The Mental Welfare Commission is concerned that 'immediate' re-

detention can extend the total period of detention well over 28 days before a tribunal hearing properly tests the grounds for detention. We would consider this to be open to legal challenge. We will write to the service to seek a review of the circumstances which resulted in this error, and ensure that the patient is advised of their rights in this instance.

## **Rights and restrictions**

The wards operate a locked door policy in response to the needs of the patients within the unit. We heard that there is a plan to develop the garden area, accessed from the ward, to add handrails and replace the stone chips with more suitable ground material. Patients could then freely access an outside area. Given the high levels of distress we witnessed during this visit, we would suggest that this development should be progressed as soon as possible, offering patients this option of outside space to reduce distress.

We heard from a carer that they were concerned about the dignity and privacy of their family member arising from the mixed sex nature of the ward. We noted that this was addressed within care plans with clear information about interventions required in these instances. We also heard of a carer's support service, which operates within the wards that can offer additional support in relation to specific concerns. Senior charge nurses make themselves available to carers to discuss particular issues and agree a suitable care plan to address concerns.

There was awareness of where a Power of Attorney was in place and evidence of consultation with proxy decision makers in relation to patient care.

We heard that carer involvement is encouraged within the wards, and that visiting can be flexible to make sure this happens.

## **Recommendation 3:**

Managers should progress the development of the garden area as a priority to offer access to safe outside space for patients who are experiencing stress and distress.

## **Activity and occupation**

Within Ward 4 there is a 30 hour post dedicated to coordinating meaningful activity. There was a timetable which evidenced the involvement of physiotherapy and occupational therapy input, as well as art therapy, Therapet and volunteer activity.

Within Ward 5, there was evidence of some meaningful activity, but the coordination and organisation of this relied on the existing staffing complement. Therefore, it was dependent on clinical need and as a result could not always be prioritised.

Given the levels of patients' stress and distress we witnessed during the visit, involvement in meaningful activity is crucial in reducing this and should be viewed as a vital component of patients' care and treatment.

In addition, we heard from a carer that they felt that there was a lack of structured activity and this contributed to his relative's distress. While there was an appreciation that staff were busy managing a high level of need, there was a view that engagement in meaningful activity might in fact reduce this pressure and foster a more settled environment.

#### **Recommendation 4:**

Managers should review activity coordination capacity across both wards to ensure meaningful activity is available to all patients.

#### **The physical environment**

A recommendation from the previous visit was to consider how the environment might be changed to provide a more appropriate setting.

During this visit, we saw evidence that some action had been taken to address this with the addition of some colour and artwork. However, the environment remains clinical and bare, and could be improved by the involvement of patients, where possible, and carers.

We heard that more access to outside space for the wards is being planned. There is currently a garden area, but this requires additional improvement to ensure it is fit for purpose. We would welcome this addition to the environment.

#### **Recommendation 5:**

Managers should consider how patients/carers can contribute to decision making about the environment for the comfort of patients with mental illness.

#### **Summary of recommendations**

1. Managers should continue to develop person-centred care planning to include a more detailed description of intervention to alleviate distress for individual patients.
2. Managers should ensure patient information is recorded in a consistent way across the MDT, and is easily accessible, either electronically or in paper form.
3. Managers should consider progressing the development of the garden area as a priority to offer access to safe outside space for patients who are experiencing stress and distress.
4. Managers should review activity coordination capacity across both wards to ensure meaningful activity is available to all patients.
5. Managers should consider how patients/carers can contribute to decision making about the environment for the comfort of patients with mental illness.

## **Good practice**

The wards have a clinical management team group and have driven a number of improvements and training for the wards. The group consists of medical, nursing and allied health professional colleagues and a dementia nurse consultant. The group also act as a liaison between acute services and wards 4 and 5. This has been a positive support when considering the most appropriate clinical setting for a patient, based on presenting need and stage in their treatment.

We heard of an audit of the use of 'as required' medication which is currently underway to analyse themes around the use of this treatment e.g. times of the day and particular triggers. This information will contribute to planning services, which can target root causes rather than requiring additional medication.

## **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.

**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](mailto:enquiries@mwscot.org.uk)

website: [www.mwscot.org.uk](http://www.mwscot.org.uk)

