Mental Welfare Commission for Scotland

Report on an unannounced visit to:
Forth Valley Royal Hospital, Ward 5, Stirling Road, Larbert, FK5 4WR

Date of visit: 8 October 2024

Where we visited

Ward 5 is a mixed-sex, 24-bedded unit for older adults from the Falkirk, Stirling, and Clackmannanshire council areas. It provides assessment, care and treatment for individuals experiencing functional illness and individuals with an early diagnosis of dementia.

On the day of our visit, there were 24 people in the ward, five of whom were considered to have their discharge from hospital delayed. Delayed discharge occurs when an individual is clinically ready, however, unable to leave hospital due to a lack of necessary care, support or accommodation available. We were told for these individuals, it was due to a lack of care home placements; we heard that dynamic discharge meetings took place weekly.

We last visited this service in October 2023 on an announced visit and made recommendations on the availability of clinical supervision, participation of individuals in their care plans, auditing of the nursing care plans and some environmental issues.

The service responded to the recommendations advising us of changes, including management supervision taking place on a rotational basis, with a minimum frequency of every eight weeks. In relation to nursing care plans and participation, one-to-one reviews were increased, and a copy of the nursing care plans offered to individuals for their own record.

An audit tool incorporating the Commission's care plan guidance was also designed. Some environmental improvements were made to address the lack of communal space available, this included repurposing facilities and extending the use of the enclosed garden as an additional visiting area.

Who we met with

We met 14 people in person and reviewed the care notes of 12. We were also able to speak with two relatives during the visit.

With the visit being unannounced, we did not have an opportunity to meet with managers beforehand. The senior charge nurse (SCN) was unavailable until later in the day due to other commitments, so we were initially assisted by the SCN from the neighbouring older adult admission ward; we were able to speak with the deputy charge nurse and other nursing staff throughout the day.

At the end of the visit, we met virtually with other managers to provide initial feedback from our visit. Those attending included the senior charge nurse, the clinical nurse manager, the chief nurse for mental health, and the clinical director for old age psychiatry.

Commission visitors

Denise McLellan, nursing officer

Lesley Paterson, senior manager (practitioners)

Anne Buchanan, nursing officer

Sandra Rae, social work officer

Lee Whittaker, student nurse

What people told us and what we found

Care, treatment, support, and participation

Overall, the feedback from people we met with was mixed. Although we spoke with them individually, we found that there was a consistent theme in relation to a lack of structured activity and of them finding days “long and boring with just your thoughts to keep you going”. One person was satisfied with what was available and they said that they regularly attended arts and crafts and bingo; we did hear from nearly all that we spoke with about the positive impact of the weekly visit from the therapet dog.

The environment was described as “noisy” at times, and we noted one person wearing a jacket in their room because they found it cold. Another told us they were happy with all aspects of care and particularly satisfied with the quality and variety of food provided, however, another had arranged for a relative to supply “healthier” options, including fruits and non-processed foods. Someone else felt that mealtimes should be reviewed. They said that although lunch was generally served at 12:30 and the evening meal at 16:30, sometimes this could be as early as 16:00 which they felt was not a sufficient interval between the meals. They also highlighted that there was no menu provided in advance. We did note that there was a menu board and heard that staff would offer a choice, although this was at the time when people were sitting for the meal, giving limited time to choose.

We were informed that some of these issues had been raised in community meetings and there would be consideration given to suggestions for alternatives, such as salads, wraps and other options.

In terms of how involved in their care and treatment people considered themselves, again this varied. Some individuals spoke positively about multiprofessional involvement in their care and treatment whereas others wished to highlight that they did not participate in meetings and had little awareness of their care plan or their progress since admission. One person expressed uncertainty about whether there had been any engagement with their family, despite there being an active welfare power of attorney in place. Another told us they had weekly reviews with their consultant psychiatrist and treatment from physiotherapy.

Nursing staff were described as “absolutely lovely” and that they treated people respectfully, but some were described as “better than others at listening”. An individual spoke of their discomfort in relation to how some nursing staff spoke to people, describing it as “infantile”. We discussed this during feedback at the end of the visit.

Some spoke of the lack of staff, although acknowledged that nursing staff were busy; they considered it particularly frustrating when staff would say they would

come back to them with answers to specific queries, but this would then appear to be forgotten about. We observed one individual in a communal area who appeared confused, dishevelled, unkempt and partially dressed.

We were pleased to hear from one relative who considered staff to be "wonderful and understanding of the pressures experienced in caring for their relative prior to admission". They said they were kept informed about progress and felt comfortable approaching staff if additional information needed to be shared.

We saw information displayed about a local carers' resource and they confirmed that nursing staff had told them this about this separately. Additionally, they found it very reassuring that they were able to contact the consultant psychiatrist directly via email and often received a response on the same day. This relative had an awareness of the admission status of their family member and understood the rights of being able to leave. They acknowledged additional involvement from the psychologist where views were sought about progress or changes prior to sessions commencing with the individual; we heard that they felt involved and informed in all aspects of their relative's care and treatment.

On reviewing the records, we saw evidence of physical health assessments with referrals to appropriate services as indicated, including to a general practitioner (GP) service for physical health concerns. Physical health monitoring was good with physical observations recorded using the national early warning score (NEWS) in accordance with assessed need. Medication was reviewed weekly, and we saw plans to include an individual in discussion about psychotropic medication, offering them a choice of treatment, given their previous experience of side effects from other medication.

Care records

Individual records were held on Care Partner, the electronic health record management system which was in place across NHS Forth Valley. We found this relatively easy to navigate.

Overall, records were up to date with clear plans for care and treatment. However, some, particularly in relation to the continuation notes, lacked detail in terms of describing the daily presentation or where staff had provided one-to-one engagement or other intervention. One individual was described as "delusional" with no further detail noted about what these thoughts were. In some, we saw generic language used such as "visible throughout the duty" and "pleasant". A more descriptive narrative would have helped provide information about an individual's current strengths, as well as areas of need that continued to be challenging for them. Frequency of one-to-one meetings with nursing staff was variable, and we found one record that was last updated three months before. Given this had been an area for

improvement in the action plan, it was disappointing to see this had not been reviewed more recently.

Recommendation 1:
Managers should ensure that continuation notes are detailed and enable clear interpretation of clinical presentation, progress and ongoing challenges for the individual.

A whiteboard in the nursing office also recorded information about individuals, including admission details, risks and legal status. Unfortunately, there was sensitive and identifiable data on this board, and it was visible from a large window that could be seen from the corridor. We discussed the use of a cover / screen to prevent others viewing this information. The clinical nurse manager (CNM) agreed to address this.

Information regarding 'do not attempt cardiopulmonary resuscitation' (DNACPR) was unclear and we were unable to locate documentation in relation to this for two individuals. All relevant healthcare staff that are involved in an individual's care should be aware that a decision not to give CPR has been made and documented on a DNACPR form. This not only ensures that CPR treatment is not erroneously withheld, but also that where CPR has been documented as not to be given, for any specific reason that the individual or their family has identified, then it should not be attempted.

Recommendation 2:
Managers should ensure that all DNACPR decisions and paperwork is reviewed and that there is a consistent system to ensure that all staff members are aware of the DNACPR status of every individual on the ward.

Care planning
We found examples of person-centred care plans encouraging use of the person's existing skills and we could see information about interventions. In one, the language was clear; however, it was written in the third person, therefore about the individual as opposed to in collaboration with them. It was recorded that they appeared happy with it, however, we were unable to see their participation and it had not been signed by them, nor explanation given as to why not.

For some it was difficult to see where the person had been involved in care planning or MDT meetings. For another, we were pleased to see that attempts had been made to involve them and although they had declined, this was clearly documented and evidenced by the inclusion of their uploaded signature confirming this. Some of the care plan reviews documented progress, but we found them to lack detail about these changes. Given that the level of capacity for some people was diminished, we

would have expected to see evidence of relative/carer involvement recorded in the reviews.

We found a care plan for someone whose presentation required one-to-one enhanced nursing support. Although the improving observation practice framework was referenced, it was difficult to see how staff were engaging with this individual or what therapeutic activities had taken place. There were concerns about safety due to hostility and behaviours that challenge. We considered that it would have been helpful to have a greater focus on understanding triggers and the supportive strategies that could have been used to safely manage this.

One of the records we reviewed included a comprehensive initial assessment which showed a real understanding of the person and their needs. The goals of the nursing care plans developed from this assessment were detailed and realistic for the individual. We discussed this with managers at our feedback meeting and were informed it was written by colleagues from the mental health acute assessment and treatment service. It was suggested this could be used as an exemplar for improvement.

Recommendation 3:
Managers should ensure that care plans record clear interventions needed to support movement to the care goal and include summative evaluations that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

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.

Multidisciplinary team (MDT)
The ward had a well-represented MDT including psychiatry, nursing, occupational therapy (OT), psychology, physiotherapy and pharmacy involvement. Referrals to other services were made where required. An example of this was the involvement of a Parkinson's nurse specialist for one individual.

Information on attendance was recorded and evidenced participation by all clinical staff. The team met weekly for an overview of the previous week and to determine whether planned actions had been completed. Treatment was discussed and reviewed along with risk assessments and management planning. Actions included the progress needed in relation to the involvement of social work, arranging pass medication, liaison with the 'home first team' and arranging an OT functional assessment for a single shared assessment for discharge planning.

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

We saw evidence of discussion with families to consider the next steps but noted they did not attend the formal MDT meeting. However, communication with relatives and carers was evident throughout the case records, particularly in relation to discharge planning. Views were gathered from contact with nursing staff, and we did hear from one relative of their additional contact from the consultant psychiatrist and psychology.

We felt there was a lack of meaningful individual participation in the MDT meeting process and would like to have seen individuals included more, especially as they moved towards discharge, so that their understanding could be maximised, increasing opportunities for a safe and successful discharge.

Recommendation 4:
Managers should ensure that an individual's meaningful participation in the MDT process is recorded to evidence their understanding of treatment and discharge planning.

Use of mental health and incapacity legislation

On the day of our visit nine individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was in place and held on Care Partner. People we met were generally aware of their detention status with one person being clear on their specific order and who told us that they kept a paper copy in a file in their room.

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 consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were all available and in place where required. However, there was a signed T2 consent form that did not list each medication individually. We also noted that a mood stabiliser had been prescribed, however, was not authorised on the corresponding T3 certificate.

Treatment certificates were available on Care Partner and also stored in hard copy format. We discovered a copy of an old T3 dated 2017 kept along with the current paperwork. To avoid confusion regarding the authority in place, previous copies of treatment certificates should be archived. We highlighted these issues during our feedback meeting.

Recommendation 5:
Managers should ensure that all psychotropic medication given under part 16 of the Mental Health Act is legally authorised and the consent forms used by the responsible medical officer to record consent should also detail the treatment which is being consented to.

When someone is no longer able to make decisions about their own welfare, a court can appoint someone to make decisions for them in accordance with the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). This person is known as a welfare guardian and can be a partner, family member, friend or social worker. For one individual we were unable to locate a copy of the welfare powers granted in the records. This can lead to confusion and misunderstanding about the authority for decision making.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision makers and record this on the form.

We found that although four individuals were subject to this part of the AWI Act, only three had the necessary section 47 certificate in place and one of these did not have an accompanying treatment plan. One person had a covert medication pathway written over one month before which was pending pharmacy input, so required updating. We highlighted this during feedback.

The Commission has produced good practice guidance on the use of covert medication.[2]

Rights and restrictions

Ward 5 is an open ward however the door was monitored by nursing staff to reduce the risk for individuals who were detained. When the door needed to be locked, the bell could be used for individuals and relatives to gain access. There was a policy in relation to this. One person who was admitted on an informal basis confirmed their awareness of being able to leave hospital if they chose but had a willingness to work with the MDT to plan a successful discharge. Another told us that although their preference was to be at home, they recognised that until an appropriate care package was arranged, neither they, nor their spouse would manage. This person had previously accessed the independent advocacy service and said they would approach nursing staff for re-referral if they wished further involvement.

Most people we spoke to said they were aware of their rights and had legal representation and regular access to advocacy for support at mental health tribunals if desired.

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 patient is a specified person in relation to this and where restrictions are introduced, it is

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

important that the principle of least restriction is applied. We noted that two individuals had been designated as specified persons to authorise restrictions on their telephone use, but there was some confusion among nursing staff regarding this. We were initially unable to locate the required paperwork. However, on request a member of nursing staff printed off copies for us and added them to the relevant care records.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[3].

The Commission has developed *Rights in Mind.*[4] 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.

Activity and occupation

People told us there was a lack of therapeutic activity and stimulation on the ward to improve wellbeing and that they found this unhelpful. We were disappointed to hear this, as we noted this to be positive on our previous visit. We also observed that the activity planner on the wall of the ward was blank for the entire week.

We were told that the activity co-ordinator was on leave, however, this should have been covered. Some described a lack of activity generally, while another person said that while they had been approached, the choice offered held little appeal for them.

The notes for one individual reflected regular engagement with the OT and their participation in an art group and games to alleviate stress and distress. Otherwise, we found limited evidence of whether activities had been offered and encouraged but declined by some individuals.

Recommendation 6:
Managers should ensure individuals have access to a variety of activity daily and person-centred care plans reflect individuals' preferences. They should also ensure that activity participation is recorded and evaluated or documented where this has been declined.

The physical environment

The layout of the ward consisted of 24 individual bedrooms with en-suite facilities. We found them to be clean and bright and some had been personalised with pictures and personal belongings. Each room had a whiteboard so that pertinent information

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

could be added and in one room we saw this completed with details of the named nurse and consultant.

There was also a variety of wall art, books and jigsaw puzzles on a shelf. On our last visit we noted a lack of communal space. In particular, the lounge and dining areas were small in relation to the number of people accessing them. Some improvements had been made including using the garden for visiting when weather permitted, as previously individuals needed to use their bedrooms. Ligature point reduction work required further action, and we were told this continued to be risk assessed given the nature of people's illness and increased risk of harm. Consideration was being given to whether there could be two separate sittings for meals to reduce overcrowding.

We had noted the smell of cigarette smoke from one individual's bedroom and discussed with managers legislation prohibiting smoking in NHS hospitals in Scotland. We were told that there has been ongoing liaison with another health board for guidance on how this was successfully implemented. We will continue to monitor this as the law extending the prohibition of smoking within 15 metres of an NHS hospital building was brought into effect in 2022.

Recommendation 7:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

Any other comments

We were pleased to learn that community meetings were held fortnightly giving people an opportunity to collectively raise their concerns and make suggestions for improvement.

We were advised that a welcome to the ward pack was being developed. Once completed it was hoped that individuals and their families would find it helpful and informative, especially at a time of acute distress when people were less able to absorb information. The pack would include details about the ward, the ethos of the ward and what to expect for the first few days of admission. It will provide information about medical treatment and therapies as well as information about the disciplines who may support people in their recovery, including photographs of some of the individuals in the team. The care planning process would be explained as well as how inclusion of families would happen, where an individual consents. Advice about the types of admission would be provided and that further details could be requested, as well as information about independent advocacy. Also included would be an explanation about searching and restrictions on access at times, which referenced corresponding ward policy. Included also was an acknowledgement of peoples' rights in relation to leaving the ward if not detained by legislation.

Summary of recommendations

Recommendation 1:
Managers should ensure that continuation notes are detailed and enable clear interpretation of clinical presentation, progress and ongoing challenges for the individual.

Recommendation 2:
Managers should ensure that all DNACPR decisions and paperwork is reviewed and that there is a consistent system to ensure that all staff members are aware of the DNACPR status of every individual on the ward.

Recommendation 3:
Managers should ensure that care plans record clear interventions needed to support movement to the care goal and include summative evaluations that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

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Managers should ensure that all psychotropic medication given under part 16 of the Mental Health Act is legally authorised and the consent forms used by the responsible medical officer to record consent should also detail the treatment which is being consented to.

Recommendation 6:
Managers should ensure individuals have access to a variety of activity daily and person-centred care plans reflect individuals' preferences. They should also ensure that activity participation is recorded and evaluated or documented where this has been declined.

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Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

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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