Mental Welfare Commission for Scotland

Report on unannounced visit to:
Forth Valley Royal Hospital, Ward 1, IPCU, Stirling Road, Larbert, FK5 4WR

Date of visit: 11 November 2024

Where we visited

Ward 1 is a six-bedded intensive psychiatric care unit (IPCU) located in the mental health unit of Forth Valley Royal Hospital. The unit covers the NHS Forth Valley area and has capacity for a further two contingency beds. An IPCU provides assessment and treatment for adults presenting with increased clinical risk who may require higher levels of observation and intervention, IPCUs are locked wards.

On the day of our visit, there were three people in the ward and three vacant beds.

We last visited this service in October 2023 on an announced visit and made recommendations on activity provision, environmental improvements and staff supervision. We received a response from the service with actions planned to increase the level of meaningful activity provided. We were advised that individuals were consulted at ward community meetings for suggestions on meaningful activities and materials needed were purchased using ward funds. Soft furnishings were ordered and artwork was used to the soften the overall environment. Additionally, reflective practice and managerial supervision had been planned.

Who we met with

We met with one individual and reviewed the care notes of all three. We were also able to meet one relative.

We spoke with the senior charge nurse (SCN), clinical nurse manager (CNM), responsible medical officer (RMO) and nursing staff during our visit.

Commission visitors

Denise McLellan, nursing officer

Lesley Paterson, senior manager (practitioners)

Ahmad Allam, medical officer

What people told us and what we found

Due to there being only a few individuals in the ward at the time of our visit, feedback was limited. We were able to speak with one individual and one relative although we also met with staff.

We heard a mixed account of care and treatment. In general, the individual we heard from described the nursing team as friendly and supportive, however, they did state there were exceptions to this and thought that this may may be due to a lack of training for some. We heard that sometimes the ward was understaffed and the individual said that they did not feel they always received adequate one-to-one interactions when they needed them. They advised us that at times they felt frustrated and under stimulated. We asked whether they had been informed of their rights and heard that they were aware of these from past admissions, but felt information was less forthcoming this time. We discussed these comments with managers during the feedback meeting.

The relative we spoke to provided positive feedback, describing staff as friendly, that they tried to be helpful and that information was always forthcoming, whether it was face-to-face communication or with telephone contact. They were of the view individual preferences were regarded, giving an example of alternative dietary requirements being catered for. They confirmed that there was a regular invitation to weekly multidisciplinary team meeting (MDT) to discuss their relative's progress. Their experience of meeting staff was positive and helped them feel comfortable to ask questions as needed.

We met with medical and nursing staff who told us about the impact of the pandemic on the ward and the challenges that this had brought, although they did add that things were now improving. There had been significant change to the staff team since our last visit and we were advised that developments through quality improvement had been maintained.

We noted that the ward continued to make changes and progress with individuals' care and treatment, as well for the MDT. Staff told us that they were happier and felt more supported over the last year and we heard that they received regular clinical supervision and had access to reflective practice sessions delivered by psychology colleagues. The staff team acknowledged an increase in the variety and provision of therapeutic activity offered in Ward 1 and spoke of the associated benefits of this.

Care, treatment, support, and participation

Care records

Individual records were held on Care Partner, the electronic health record management system in place across NHS Forth Valley. We found this relatively easy to navigate. In reviewing the care records, we could see that the frequency and level

of detail recorded in the care records had improved and now included a wider range of disciplines in comparison to our last visit.

Care plans covered both physical and mental health needs. They were detailed and mostly corresponded to the assessed needs. They were however, written in a way that appeared to be directed at the individual as opposed to being written collaboratively. We discussed this with managers who said that individuals met with key workers/named nurses and were involved in writing the plans.

Recommendation 1:
Managers should ensure individuals' participation in care planning is evidenced in the care file.

We found that the care plans started with the individual's name at the front of the specific care plan but advised managers that this did not provide a person-centred approach as to how the person had expressed their own views, their understanding of their needs or their preferences. We noted that the care plans were reviewed regularly, although some did not have signatures or a reason given where the care plan or interventions were not agreed. We were aware from visits to other wards that signed care plans can be uploaded to Care Partner. We suggested that additional auditing of care plans was required to help direct and guide staff.

There were frequent entries regarding continuous interventions, which we found to be detailed. The MDT meeting record was informative and there was evidence of relative's involvement and discussion. Risk assessments and management plans were completed in a timely way, using the functional analysis of care environments document (FACE). Copies of the FACE risk assessments were available and up to date.

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 MDT was well represented by a variety of professionals including the responsible medical officer (RMO)/consultant psychiatrist, nursing staff, psychology, occupational therapy (OT), activity co-ordinators and pharmacy.

MDT meetings were weekly, and individuals and their relatives/carers were invited to attend. The meeting template document was comprehensive and provided a structure for information to be gathered in an organised way.

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

Use of mental health and incapacity legislation

On the day of the visit, all three individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) with the relevant documentation easily accessible on Care Partner.

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 one individual had been prescribed medication that had not been authorised on the corresponding certificate, and another where the clinical team was unaware a valid certificate authorising treatment (T3B) that was already in place. The current treatment plan was not compliant with this.

We also noted that a high dose medication monitoring alert should be added to the Care Partner notes for this individual. The RMO confirmed these issues would be rectified.

Recommendation 2:
Managers should ensure that all psychotropic medication prescribed is authorised appropriately. There should be governance in place to look at whether authorisation already exists ensuring any changes to treatment correspond with this.

Rights and restrictions

The IPCU operated a locked door policy commensurate with the level of risk. We heard from one individual that they had not been given any information about this episode of detention but were familiar with the process and had since been supported to access the independent advocacy service in relation to whether they wished to appeal their detention.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where individuals had nominated a named person, we found this information available in the care records.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. The Mental Health Act requires that where this is overridden the reasons for doing so are notified to them and their named person in writing and that the Mental Welfare Commission for Scotland is also informed.

We saw a copy of an advance statement on file specifying that the person did not want to be given medication by intramuscular route (depot), however, they were currently prescribed depot medication. There had been no advance statement override completed due to the clinical team being unaware of the advance statement. We highlighted this to the RMO and advised that the individual had been given treatment without authorisation, that this would need to be explained to them and their named person, both verbally and in writing.

Recommendation 3:
Managers should ensure that an individual's advance statement is taken into account when considering care and treatment.

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 an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

Where specified person restrictions were in place under the Mental Health Act, we found that one person had restrictions on their phone use. Although the rationale for doing so was clear, they had been specified for safety and security in hospital (RES1) without the required RES3 being completed. The individual subsequently agreed to give the phone to staff at night to help promote sleep. After discussion with the MDT regarding this, we were advised that had been a misunderstanding about whose role it was to complete the RES3. Advice was given that the relevant RES3 form should be completed by the RMO and that the individual, named person and the Commission be informed verbally and in writing that the phone had been removed without legal powers.

We found that another individual had a care plan relating to illicit drug use and urine drug screening (UDS). This person was not subject to any specified person legislation and their care records did not indicate how the process had been explained to them or whether the individual had given informed consent to this procedure. We discussed with the staff team whether the individual would have been able to give informed consent and with the current situation, they were effectively being tested by UDS without the appropriate safeguards in place.

Recommendation 4:
Managers should ensure that specified persons authorisation is completed in accordance with current legislation.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[2].

We observed one person who required to be nursed by continuous intervention (CI) by two members of staff. This level of intervention was necessary to provide additional care and support and to minimise risks to the individual and others. Although the individual's room was in a separate corridor to others, the door was not locked, and they were able to move freely around the ward. Information about the use of CI was clearly documented in the individual's care plan.

We were told that the ward did not have a seclusion policy although this was being developed and was awaiting ratification.

The Commission has developed *Rights in Mind.*[3] 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

When we visited last year, we were disappointed by the lack of activity and made a recommendation about this. Although the ward already had input from activity co-ordinators, we heard that there had been staff absence, and this provision was shared between other wards in the inpatient unit. We were pleased to note improvements that now included using the shift system to allocate a designated member of the nursing team to undertake the responsibility for activities, augmenting their delivery across the seven-day period.

Activities were planned on Mondays, in conjunction with individuals admitted to the ward. Groups included smoothie making, yoga, relaxation, decider skills, gardening, arts and crafts. There was also pet therapy, gym sessions, board games, quizzes, movie night, self-care and pamper sessions with face masks, pool and football tables and a badminton net in the garden area. There was also an Xbox that was accessible in the quiet room.

We were told meetings were held monthly to discuss activities and allocation of endowment funding for this. We also heard about a large sum of money raised through sponsorship from staff participating in a half marathon event. As well as providing an additional resource, it had brought the added benefit of boosting morale for the staff and unit and created a working alliance towards a specific goal.

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

The physical environment

The entrance to the ward was welcoming and gave an immediate positive impression. It was bright and clean with affirmations displayed along the corridor walls.

The general layout was unchanged from our last visit and consisted of two main corridors mostly with single en-suite rooms leading off the central day area. A separate dining room, quiet room, and laundry area could be accessed from the day area and the nursing office was adjacent to this. The visiting room was in the corridor at the entrance to the ward with other non-clinical rooms.

We were pleased to see that improvements had been made to the communal areas to soften the stark clinical appearance of the unit that was seen previously. The décor had been freshened up, and we saw colourful artwork and information boards. Information displayed in the day area included guidance on person-centred care planning aimed at individuals admitted to the ward and helped to give a clearer explanation on their purpose.

We were told that bed capacity had reduced over the years so this would give scope for further improvement for the mental health unit to be achieved in the future. In some of the bedrooms with en-suite shower rooms we noted staining on the flooring and bubbling to the wall boards. We were told that repairs were being proactively pursued with the estates department on a weekly basis. Anti-ligature work remained outstanding, and we were told this continued to be risk assessed given the nature of people's illness and increased risk of harm.

The garden area was tidy and well maintained, and we could see that efforts had been made to make this space more functional. Individuals were encouraged to participate in the gardening group to help keep this an inviting space for all. A badminton net had been purchased, and the ward had also benefitted from new seating and cushions purchased from a donation made by the local Round Table charity organisation.

Any other comments

We saw improvements with the support provided to the relatively new staff group in the ward. There had been investment made with quality improvement work, education and in staff meetings which had been minuted and made available for any staff not able to attend. There was also the addition of a 'shout out' board which included feedback for individuals to foster support, recognition and encouragement to staff who were working in challenging situations.

Summary of recommendations

Recommendation 1:
Managers should ensure individuals' participation in care planning is evidenced in the care records.

Recommendation 2:
Managers should ensure that all psychotropic medication prescribed is authorised appropriately. There should be governance in place to look at whether authorisation already exists ensuring any changes to treatment correspond with this.

Recommendation 3:
Managers should ensure that an individual's advance statement is taken into account when considering care and treatment.

Recommendation 4:
Managers should ensure that specified persons authorisation is completed in accordance with current legislation.

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.

Contact details

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

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk