Mental Welfare Commission for Scotland

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

Date of visit: 14 January 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Ward 4 is a 16-bedded, mixed-gender dementia assessment unit, primarily for adults aged over 65.

We last visited this service in January 2024 as an announced visit and did not make any recommendations.

On the day of this visit 15 people were in the ward, 12 of whom were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Five people were considered as being 'delayed discharges.; 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.

Who we met with

We met with and reviewed the care of seven people. Of those seven, we reviewed the care notes of six. Due to the progression of illness, we were unable to have in-depth conversations with many individuals, but we were able to observe them at various points throughout the day. We also met three relatives.

Prior to our visit we had an online meeting with the senior charge nurse (SCN) and the clinical nurse manager (CNM). On the day of the visit, we had discussions with one of the deputy senior charge nurses (DSCN), the nursing team and medical staff.

Commission visitors

Denise McLellan, nursing officer

Gordon McNelis, nursing officer

Sandra Rae, social work officer

What people told us and what we found

Although we were unable to have a fuller discussion with individuals, we observed warm interactions between them and staff. We saw examples of staff working with people experiencing stress and distress and behaviours that challenged.

Generally, staff were described as “helpful” but there was a sense from people that they felt “bored and had nothing to do.” Individuals were unfamiliar with their legal status, but this may have been associated with their cognitive impairment.

They did not express any concerns about the environment, with some people being positive about the meals that were provided.

Relatives we spoke to provided more detailed feedback, describing the team as “compassionate”, “very attentive”, “helpful” and that they provided excellent care and treated people as individuals. They also heard that the ward maintained regular contact with families and carers, and we were told that carers “could not compliment them enough”. It was evident that families and carers felt welcomed and were given sufficient opportunity to maintain contact and encouraged to remain involved in their relatives’ care.

We heard from the nursing staff that we spoke with that Ward 4 was considered as a first choice by newly qualified nurses because of the learning experience it offered in helping them to increase their knowledge and develop skills. We heard that former nursing students had found their placement in Ward 4 to be rewarding and described a leadership culture that was nurturing and supportive. We were pleased to hear that there was regular supervision and reflective discussions and that it remained a positive environment.

In relation to staffing levels, although there continued to be cover provided through use of bank staff, there had been a reduction following successful recruitment drives. The service told us they remained committed to reducing this further. We were also told that in the mornings, when assistance with needed with activities of daily living was the priority, additional support was accessed from other wards in the mental health unit. Additionally, a further DSCN had been recruited to the ward in line with the changes made across NHS Forth Valley inpatient mental health services.

On our last visit we were informed of plans to improve the environment through the repurposing of some rooms. We were pleased to see that changes had been made to the building which proactively minimised stress and distress for this group of people.

Care, treatment, support, and participation

We were pleased to find the multidisciplinary team (MDT) continued to maintain a focus on person-centred care and treatment and that improvement in carer

engagement had been sustained. One relative described the care and treatment as “excellent - second to none” and told us they were kept involved in all aspects. They told us they were provided with regular updates from nursing staff during visits and by other professionals, as needed. They spoke of their views being considered in family meetings and how they felt “included and informed.” Another spoke of being an advocate for their relative and how they were able to liaise with professionals to try to uphold and deliver on their relative’s previous wishes. The views we heard were that there were “real attempts to keep the family involved.”

The use of psychological formulation ensured the team understood potential triggers and interventions that focussed on reducing levels of stress and distress. Where we saw people experiencing this, it was managed with a supportive, caring approach, safeguarding everyone without the need for physical restraint or additional medication. Detailed person-centred care plans highlighted needs in relation to physical health and personal care, as well as mental health needs.

We asked about the individuals whose discharges had been delayed. We were told that although improvements had been made with the provision of packages of care, sourcing care home placement continued to be a challenge. The lack of suitable placements had affected all five individuals on the ward.

Care records

Care records were held electronically on the ‘Care Partner’ recording system which we found relatively easy to navigate.

The care records were comprehensive, and we were able to access several key documents from all disciplines who input information. Where referrals had been made to allied health professionals (AHPs) we could see which member of the team was delivering specific interventions, outcomes, and progress. We found a broad range of care assessment records including some from pharmacy, occupational therapy (OT) and physiotherapy.

From the thorough initial assessment onwards, records were documented in a way that made an individual’s journey easy to follow. Physical health care needs were detailed in care plans, and we saw completed assessments and ongoing monitoring, including the use of the malnutrition universal screening tool (MUST) and national early warning score (NEWS). The emphasis on this aspect of care and treatment was positive to see, given the significance of physical health in older people with dementia and were pleased to hear that the ward had access to a registered nurse (RGN) who specialised in wound care.

Dementia care plans were detailed and holistic, identifying psychological triggers, strategies and interventions to manage individuals’ needs. They were person-centred

and personalised, developed from psychological formulations and linked to risk assessment.

It was difficult to see where individuals had participated in the care planning process, although we were pleased to see the continued use of the 'Getting to know me' booklet, written collaboratively with relatives/carers; this provided valuable information about the individual to aid care planning.

Continuation notes offered a good explanation of interventions in addition to this being recorded in monthly reviews. One-to-one contacts were not always documented as such, but we could see evidence of these happening.

Other documentation included do not attempt cardiopulmonary resuscitation (DNACPR) certificates, missing person action plans, family/proxy decision maker meetings and MDT meeting records. Records were written using respectful person-centred language.

We would have liked to have seen more detail in relation to activities that individuals participated in and the associated benefits, as this was not always clear. We discussed this with managers at the feedback meeting at the end of our visit.

Multidisciplinary team (MDT)
There were a range of disciplines providing input, including mental health nurses (RMNs), consultant psychiatrists, medical staff, OT, activity co-ordinators, physiotherapy, psychology and pharmacy. Social workers did not routinely attend the weekly MDT meeting and instead participated in other meetings at relevant stages of an individual's progress.

Discharge planning meetings occurred weekly, and we were told there was a focus on improving the timescales for social work referrals; we were pleased to hear that the MDT have developed positive relationships with social work locality managers. Families/carers were not invited to the formal meeting but could attend separate family meetings, where carers' views were considered and discussed at the full MDT meeting. We found entries in the care records evidencing this as well as information about phone calls to relatives where updates from the weekly meeting were provided.

We reviewed a number of the MDT meeting records and were pleased to find a consistent approach in recording details from the meetings, with reference to previous meetings and progress made or changes required.

The meeting template guided discussion in key areas such as admission, legislation, risk, medication, diagnosis, physical health, time off the ward and family/carer perspective. There was a clear focus on consulting with families, but we found that information relating to delayed discharges could have been more robust.

Use of mental health and incapacity legislation

On the day of our visit, 12 individuals were detained under Mental Health Act. Documentation was current and easy to find in the electronic files. Those that we spoke with had a limited understanding of their legal status and rights, but we could see that some were involved with independent advocacy.

Relatives we spoke with had a clear understanding of legislation and rights and the rationale for decisions. Individuals had access to independent advocacy support from Forth Valley Advocacy and legal representation in place where the individual had requested this.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. We found that certificates authorising treatment (T3) corresponded with the psychotropic medication prescribed. T3 certificates were stored in hard copy format as well as on Care Partner. Unfortunately, one of these certificates was not available in the folder despite regular auditing being carried out. We highlighted this with the DSCN and we were able to locate the certificate on the electronic system.

For individuals who had covert medication in place, there was clear evidence of pharmacy involvement and discussion with families. The documentation was current, and recorded review information.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate 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 maker and record this on the form. On the day of the visit, we found all s47 certificates completed, with detailed treatment plans in place.

Rights and restrictions

Ward 4 continued to operate a locked door, commensurate with the level of risk identified for this group of people. On our last visit we saw the locked door policy explaining this displayed on the main door. It was not available this time and managers were surprised by this when we asked if it had been relocated. Following some discussion, it was agreed this had been an oversight following alterations to the ward entrance and this was rectified during our visit.

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 these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least

restriction is applied. On the day of our visit, no one was subject to specified persons restrictions.

The Commission has developed *Rights in Mind.*[1] 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

Dedicated activity co-ordinators provided input to the two older adult wards in the mental health unit at Forth Valley Royal Hospital. They worked closely with OT and nursing, and we saw two individuals enjoying a 'manicure and pamper' session when we arrived on the ward.

Other activities included reminiscence, listening to music, light exercise, board games and 'non cook' baking in the therapy kitchen. The ward continued to use the 'Getting to know me' booklet to identify individual likes, dislikes and hobbies.

Generally, activity continued to be ad-hoc and was provided following on from communication with nursing staff at handover and in accordance with an individual's presentation on a given day. In view of feedback offered by people telling us they were "bored" with "nothing to do", we suggest creating and introducing individual activity care plans that detail opportunities for person-centred, meaningful activities. We felt these would link well with the stress and distress care plans with the aim to promote wellbeing and reduce the need for pharmacological intervention.

The physical environment

When we last visited, we were told of plans to improve aspects of the ward layout including an increase in the communal living space and changes to the entrance aimed at reducing the distress and response that can arise as individuals try to exit the ward. Alterations were complete and we saw positive change to the environment.

One large room, previously used for meetings had been converted into a lounge. It was well organised with bespoke storage creatively built along two of the walls. Some of the cabinets had been designed so that relevant reminiscence material could be displayed. The addition of acoustic panels to the ceiling had helped to minimise the impact of noise. This change will be evaluated and it is hoped that over time, it will lead to a reduction in stress and distress and the administration of 'as required' medication.

An additional resource was created by modifying a small room previously used to store admin materials. The function of this space had changed to create a sensory environment which could assist with de-escalation. It was decorated to create a soft

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

and relaxing environment and the room benefitted from a virtual sky light on the ceiling created by an LED lighting panel featuring a nature scene.

The main entrance area had been remodelled to create an 'airlock' system creating an additional barrier at the exit to help redirect individuals who may be seeking to leave, as well as reducing its appearance as an obvious exit to reduce any associated distress. On the day of the visit the doorbell was not working. We were told this had been reported but as an interim measure, there should have been a sticker with the ward telephone number placed over it. It was thought this may have been removed and we were told this would be addressed.

As a consequence of action taken to maximise living resources, there was a lack of storage facilities. We observed a bathroom being used to store a laptop table as well as a crash mat. The lack of storage was acknowledged, and the team will continue to explore how this can be addressed. We also found the therapy kitchen to be disorganised and felt this would be confusing for individuals who were being supported to use it. We discussed this in our feedback meeting at the end of the visit, and it was agreed this could be reviewed to see what improvements could be achieved.

Although complemented by a dementia-friendly garden, we were disappointed to find several cigarette ends on the ground despite legislation prohibiting smoking in NHS hospitals in Scotland. We were aware of ongoing liaison with another health boards for guidance on how this was successfully implemented in this other area. 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 1:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

No other changes had been made to the ward layout which provided single en-suite bedrooms. This was beneficial for individuals who could seek out the company of others in the communal areas at their choosing.

Rooms were clean, bright, airy and personalised. Information gathered from the 'Getting to know me' booklets was written on white boards, helping staff and individuals to have an increased understanding and initiate discussion.

There was helpful information for families/carers displayed on notice boards at the ward entrance. As well as information about the ward, there were carers' resource material, some of which had QR codes printed on the leaflet, and these were up to date.

Aspirations included preparing a bid for a proposal to adapt one of the bedrooms into a palliative care room which would have additional flexibility for use as a stress and distress room, dependent on clinical need. In addition to this, consideration was being given to converting the original small lounge into a dedicated family room.

Other proposals included fitting additional panels to 'flashpoint' areas such as the dining room where there was a higher risk of incidents occurring. Investing in the environment evidenced the commitment the team had to continue to improve the experience of people who required to be cared for in hospital and their loved ones.

Any other comments

We were pleased to see several adaptions to the fabric of the ward, including that sound proofing had been completed. We are keen to see how these improvements will bring further positive change and help to alleviate distress for individuals. We also look forward to seeing other initiatives come to fruition if proposals are accepted and funded.

Following on from the Ward 4 team being awarded 'Nursing Team of the Year in 2023', the work of the team in the unit received a highly commended award at the Royal College of Nursing (RCN) Scotland Nurse of the Year Awards in 2024. This award recognised their dedication and commitment to patient care.

The ward-based team and AHPs have continued to promote a model of care that kept individuals at the centre of treatment decisions. We recognise the drive to include families and carers as partners in care and we were moved to hear of the support and kindness shown to one relative whose loved one had recently died. Acknowledging the impact for this carer, especially given a lack of available family, the team visited this individual at home with flowers soon after, to offer condolences. This compassionate act was done out with working hours.

Summary of recommendations

Recommendation 1:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 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 this recommendation 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