Mental Welfare Commission for Scotland

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

Date of visit: 15 January 2026

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 ward for older adults. Following assessment, the multidisciplinary team (MDT) arrange transfer to long term care placements, or step-down beds at Bo'ness and Clackmannanshire Community Hospitals until appropriate care provision is identified.

On the day of our visit, there were 13 people on the ward, with one other individual receiving medical treatment elsewhere in the hospital. There were two vacant beds. There were no delayed discharges, but two individuals had stays over 120 days, due to neither of them being clinically ready to move on. The clinical team were providing enhanced support under continuous intervention to two individuals.

We last visited this service in January 2025 on an announced basis and made one recommendation about compliance with the Smoking, Health, and Social Care (Scotland) Act, 2005. This action was completed in summer 2025, in conjunction with the wider mental health wards in Forth Valley Royal Hospital.

On the day of this visit, we wanted to follow up on our last recommendation and see the outcome of planned environmental changes discussed previously.

Who we met with

We met with three people and reviewed their care. We reviewed the care records of a further three people and also met with three relatives.

We spoke with the service manager, the senior charge nurse (SCN), the lead nurse and one of the consultant psychiatrists.

Prior to our visit, via MS teams we met with the clinical nurse manager (CNM) and one of the deputy senior charge nurses (DSCN). This provided an opportunity to gather information ahead of the visit. We learned the DSCN was moving to a seconded role as clinical governance lead for the mental health units to take forward requirements identified in the Healthcare Improvement Scotland (HIS) inspection report of 2025.

Commission visitors

Denise McLellan, nursing officer

Lesley Paterson, senior manager for practitioners

Kathleen Liddell, social work officer

What people told us and what we found

Due to their level of cognitive impairment, most of the individuals in the ward were unable to have in-depth discussions about their care and treatment or rights, but we observed staff interacting with them throughout the day. We heard from an individual who told us that the food offered was enjoyable and they enjoyed listening to jazz music. We noted individuals appeared cared for and settled around the ward and saw warm and attentive engagement.

Families acknowledged that staff took time to speak with them and offer reassurance as needed. One relative who had been a primary carer told us they were happy with the level of care and treatment their family member received, and they spoke of the clinical team providing regular updates. Another relative who held Power of Attorney told us that they felt involved and were “included, listened to and respected.” They described staff as “top notch” and the team supportive of them as the proxy decision maker in their specific role.

We heard from family members that they visited daily, at various times throughout the day and that they found their relative cared for, well-presented and the ward was always clean. They told us staff encouraged family participation and support with meals to maintain connection. They did comment their relative sometimes appeared bored and felt more person-centred activity could help with this. We received positive feedback about communication, engagement, and overall care and treatment.

Other feedback we heard was “staff are lovely, really nice, always ask how you are feeling”, “seem genuinely interested and compassionate” and “I’m happy with staff, they are a good bunch.” A relative told us, “Staff make time even although they are busy”, and for emphasis said, “if scored out of five - I’d give a 10!” Another relative remarked on the positive ambience in the ward and of being able to request a meeting if they needed further discussion.

The clinical team told us of engagement with visitors, who were greeted on entry to the ward and of telephone contact to discuss aspects of care and care planning with others.

We heard about ongoing improvements with the role of the “floor nurse” to increase observation of individuals to help manage overall risk; this role was established to increase knowledge about presenting behaviours and how sometimes when not understood, this could lead to misidentification of intent. The team had consulted with NHS Highland colleagues and shared resources. In Ward 4, they were in the process of adapting this for their setting, with guidance displayed on a poster in the nursing office. As part of environmental improvement, the team were exploring a case for adapting space in the ward to create palliative care and de-escalation areas.

Care, treatment, support, and participation

There was a clear focus on physical healthcare interventions and monitoring, with referrals to specialist services being made as needed. Psychology provided sessions to improve understanding around stress and distressed behaviours, and we also heard about ongoing work to improve sexual safety for all individuals in the ward. We learned that levels of continuous intervention had doubled in the past year in response to managing this.

The Adult Support and Protection (Scotland) Act, 2007 (the ASP Act) is set out for adults, aged 16 and over who by virtue of their disability, mental disorder, illness, physical or mental infirmity are unable to safeguard their own wellbeing, property, rights or other interests, and are more vulnerable than adults not affected by the above, and are at risk of harm, as 'adults at risk'.

Due to the progression of illness, some of the adults had increased vulnerability to be harmed or cause harm to others. We had been made aware of ASP incidents in the ward and involvement and oversight from the relevant ASP teams. The ASP team continued to support the MDT to increase knowledge and awareness. For one individual we found documentation regarding incidents, however, were unable to locate detailed, up-to-date care plans, risk assessments or risk management plans addressing the risk of harm.

We were concerned that there was a lack of clarity and documented safeguarding measures; we highlighted this to managers at the feedback meeting at the end of the visit. We were told that that sexual safety work was planned but had not yet progressed. The MDT were proposing change to the meeting template to ensure sexual safety was discussed for everyone at each meeting and exploring the risks associated with this. We were told that work was being progressed around reviewing sexual safety and safeguarding following on from the HIS inspection. We will continue to liaise with senior managers to request updates on the progress of this.

Care records

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

We found the information recorded in the chronological care records was variable. Some records were more detailed, describing how individuals spent their day, including information about levels of stress and distress. Others recorded content such as "low profile" and mainly documented aspects of personal care, fluid and nutrition. Occupation therapy (OT) documentation about types of activity and level of engagement during sessions was detailed.

Physical healthcare monitoring was good and there were evidence of falls and post restraint medical assessments being completed in a timely manner, with subsequent

monitoring and observation. Medical input was provided by the duty doctor and there was a policy in place to support patient transfers to the acute hospital where needed. We heard this worked well and the mental health bed on Ward 4 was always kept while the person received treatment elsewhere in the hospital.

The Scottish Government produced a revised policy on do not attempt cardio-pulmonary resuscitation (DNACPR). This makes it clear that where an adult who cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking whatever steps are possible to establish the wishes of the person. In all cases, this involvement or consultation should be recorded.

Of the 10 DNACPR certificates in place in Ward 4, we noted some issues with three of them. The first one recorded that a discussion with the relative was pending from July 2025 and this had not been updated since then. Another one did not have details whether review was required and the third did not select the reason for the decision.

Recommendation 1:
Managers should ensure regular audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded, and that all required information has been completed.

We saw that psychology was involved for formulation, knowledge and understanding of behaviours and where risks had increased. We asked what the criteria was for determining the input of psychology and were advised that this would be in response to seeing an increase in stress and distressed behaviours and a correlation with increased use of 'as required' medication. The MDT would liaise with psychology when it was felt input was required. A psychologist from the faculty of psychology for older people was working with nursing staff on a weekly basis to improve the quality of analysis.

Medical reviews were documented and there was evidence of contact with and participation by families. There was some evidence of participation in activities for an individual supported through continuous intervention (CI), but we found this was not recorded regularly.

The focus of the Scottish Patient Safety Programme Improving Observation in Practice (SPSP-IOP) was to replace the enhanced observation practice with a framework of proactive, responsive and personalised care and treatment. This would focus on prevention and early intervention where there is a deterioration in mental health. Two individuals were being supported under CI, but only one of them had a

specific care plan for this intervention despite there being daily notes and discussion in the MDT meeting about ongoing review. It was documented that this increased level of observation was necessary due to the individual's vulnerabilities but there was limited information about specifics or actions to manage or reduce risk in the risk management plan. The level of detail recorded was dependent on who had written the entries.

Recommendation 2:
Managers must ensure specific care plans are written for every individual receiving additional support under continuous intervention.

Risk assessments were used to identify historical, as well as current risk factors to inform arrangements needed. There was a range of care plans available covering symptoms of mental illness, dietary and fluid requirements, personal care, continence, risk to self and others, and stress and distress. We found some examples where needs had been assessed and the requirement for support documented, but there was a lack of robust detail about the interventions to meet these needs or how goals were evaluated.

Where stress and distress information was available the detailed information had not always transferred through into some care plans. Although personalised information and knowledge about preferences had been gathered, we felt this could have been used more effectively in guiding the communication approaches that could work best for individuals, rather than generic interventions. One stress and distress care plan referenced the use of intramuscular medication but did not describe the circumstances where this would be considered or what de-escalation steps should be taken beforehand. An intervention noted 'distraction techniques' would be used, however, there was no detail about what these were or who was responsible for delivering.

Risk management plans outlined areas of concerns but there was a lack of detail on strategies to be used. We felt this could lead to a lack of consistency in risk management and potential for unnecessary restrictive practices being implemented.

For older adults with a diagnosis of dementia, care plans should be specific, measurable, achievable, realistic and time (SMART) to ensure consistent, person-centred and rights-based care. SMART plans enable staff to understand support required, reduce the risk of task focussed practice and allow progress and outcomes to be evaluated in a meaningful way. We found that one care plan and risk assessment did not have comprehensive information recorded to address risk of harm in a SMART way. We raised our concern about the lack of comprehensive, SMART information and specific strategies to manage risk being recorded with senior managers. Without clear strategies or interventions being outlined in the care plans, staff would be unable to consistently manage risk, creating potential for

further harm and any safeguards under ASP Act arrangements may not be fully effective.

Recommendation 3:
Managers should ensure that care plans are written in a SMART way, including consideration of triggers or early warning signs of distress, and that reviews are detailed with a summative evaluation of the efficacy of care interventions.

Recommendation 4:
Managers must ensure the regular audit process of care records so that recorded information reflects the detail of interventions being delivered.

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 met weekly and we found detailed information in the meeting record including nursing updates, legal status, medication, risk status, and physical health needs.

The meetings were attended by medical, nursing, OT, activity co-ordinators, physiotherapy, pharmacy, and student nurses. We found collaboration with other disciplines such as speech and language therapy where involved. Mental health officers (MHOs) would attend at key points in the admission and there was evidence of discharge planning being progressed.

Although carers/families were not invited to the formal meeting, most professionals gave an open offer to families to attend separate family meetings at periods of decision points. Their views would then be discussed at the main MDT meetings.

The psychology assistant role funded from the nursing budget had stopped, having been a fixed-term post. Although the role did not involve direct case involvement, improvements made in carer engagement and participation was valued by the MDT as well as carers and families. We were told that data was being collated to explore the benefits and consideration would be given to reintroducing this.

Use of mental health and incapacity legislation

On the day of our visit, everyone in the ward was detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Documentation was up to date and easy to find in the electronic records.

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

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, we found corresponding records. We saw evidence of discussion with MHOs regarding legal status and documentation was recorded.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to people subject to detention who are either capable or incapable of consenting to specific treatments. Six certificates authorising treatment (T3) corresponded with the prescribed psychotropic medication, but we found one that had been written in a way that could have created potential risk of administration error. Following the visit there was further discussion between the responsible medical officer (RMO) and the Commission. We advised that good practice would be to stipulate authorisation clearly to reduce the potential for over administration.

For others, treatment had not reached the required period to meet the criteria, but we highlighted ones that were approaching this point. For four out of the five individuals being given medication covertly, there was clear evidence of pharmacy involvement, discussion with families and review information. The others did not include a review date and recorded it would be set by the individual's own team the following day, but this had not been actioned. The Commission has produced good practice guidance on the use of covert medication.[2]

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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. Everyone had a completed certificate available that complied with the legislation.

We were told about two significant events that had taken place on Ward 4 involving adults who lacked capacity and we reviewed the care records of the individuals involved. We noted that ASP Act referrals had been progressed and duty to inquire (DTI) processes completed. An inter-Agency referral discussion (IRD) had taken place where required, which concluded that an initial ASP case conference should be held. We were told that adult protection measures were not continued and that the matter would instead be managed under complex care management. The case conference minutes recorded that an NHS learning review would be completed, which we will review when available.

For the other event, no ASP case conference was progressed, and we were unable to see a documented rationale for this decision. This difference in approach between

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

the two local authorities was evident, given that both incidents involved significant harm. A case conference would have provided an independent, multiagency forum to support consistent risk assessment, the development of an ASP protection plan, and appropriate interventions to safeguard both individuals.

We were told that targeted work was being progressed following the incidents. While we acknowledge that embedding this work into practice takes time, it was concerning that the relevant care plans and risk assessments lacked sufficient detail, clear management strategies, and did not include a comprehensive MDT risk assessment, including social work input. Without this essential information, there is a risk that staff cannot consistently mitigate risk, implement protective measures, or ensure the rights and safety of all individuals involved.

Recommendation 5:
Managers should ensure that where harm occurs, responses, care plans, risk assessments, and risk management plans are comprehensive and robust, in order to mitigate harm as far as possible.

Rights and restrictions

Ward 4 continues to operate a locked door system, commensurate with the level of risk identified for this group of people.

There was a copy of the policy displayed at the entrance to the ward. Where individuals lacked capacity to understand their rights, we saw that a curator ad litem had been appointed by the Mental Health Tribunal for Scotland (MHTS) to support rights and to protect and uphold them during MHTS proceedings. There had been no change to independent advocacy provision and Forth Valley Advocacy continues to take referrals and visit the ward regularly.

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 these specific restrictions.

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.

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

Activity and occupation

We heard from one family who told us that they thought activities should be more frequent and person-centred as they were aware their relative sometimes got bored.

Dedicated activity co-ordinators continued to work closely with OT and nursing to provide activity in the ward. There were no individualised timetables, but we were told activities were individualised and delivered on an ad-hoc basis, guided in accordance with individuals' presentations which were communicated during handovers.

Information collated from the 'getting to know me' booklet helped identify likes, dislikes, hobbies and interests. We found documented evidence of meaningful activity linked to therapeutic benefits. For the relief of stress and distress, we saw activities such as baking, chair exercises, hand massage, word finding, light exercise, therapet visits, and quizzes.

The physical environment

The ward was accessed via an airlock entry system that had been introduced prior to our last visit. It was found to reduce stress and distress associated with exit-seeking behaviours. The entrance was welcoming with a variety of helpful information displayed on notice boards. As well as information about the ward, there was resource material, some of which had QR codes and these were up to date. In addition to this, there was a carer's corner in the corridor leading to Wards 4 and 5.

The single ensuite bedrooms were accessed from a continuous corridor and could be personalised with photographs and pictures from home. Placed on the front of the bedroom doors were A4-size laminated pictures to make identification easier. Each identifier was decorated with individuals' names and pictures that they associated with, or recognised, such as football clubs and hobbies; these had been generated by staff using AI tools.

The lounge was fitted with acoustic panelling to reduce noise impact and was well utilised with several activities taking place in this area. The dining area and TV lounge were quite small spaces, and further work was being considered as this could make them flashpoints for violence and aggression. Because of the noise levels and compactness of the dining room, some people were supported to eat elsewhere due to stress and distress experienced from being in the busier area.

There was shared access with Ward 5 to a therapy kitchen and physiotherapy gym and there was a small sensory room on the ward. This room was welcoming, brightly decorated and gave the feeling of connection to the outdoors from a virtual skylight in the ceiling. It was a peaceful and relaxing space.

The nursing office, clinical and domestic facilities were also in the ward, with additional offices in a corridor close to the ward entrance. When we last visited, we noted the communal bathroom had been used to store items, but we found it to be tidy and clear his time.

There was also access to a dementia-friendly garden adjoining the ward.

The ward was clean with no unpleasant smells. We had heard earlier of ambitions to achieve further improvement with the addition of a palliative care room and de-escalation area. We look forward to seeing any developments in future visits.

Any other comments

We were pleased to hear that noise reduction and layout change in the lounge had achieved a 62% reduction in adverse incidents and a 23% reduction in falls. This work was recognised by the team who achieved a highly commended award for low cost/high impact in the Design in Mental Health Awards 2025.

Summary of recommendations

Recommendation 1:
Managers should ensure regular audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded, and that all required information has been completed.

Recommendation 2:
Managers must ensure specific care plans are written for every individual receiving additional support under continuous intervention.

Recommendation 3:
Managers should ensure that care plans are written in a SMART way, including consideration of triggers or early warning signs of distress, and that reviews are detailed with a summative evaluation of the efficacy of care interventions.

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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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