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Unannounced Inspection Report

Mental Health Services Safe Delivery of Care Inspection

Forth Valley Royal Hospital

NHS Forth Valley

25 - 26 August 2025

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About our inspection

Background

The current Healthcare Improvement Scotland Adult Mental Health inspection programme was developed as part of a range of actions to support and improve NHS adult mental health services in Scotland in the context of the COVID-19 pandemic and beyond. Although the initial focus of this work was on Infection Prevention and Control, it was agreed with Scottish Government to broaden the inspection focus from infection prevention and control to a broader assurance function, creating a new and revised 'safe delivery of care' assurance model in NHS adult mental health units.

Our revised methodology will incorporate the HIS Quality Assurance System Quality Assurance Framework and will consider a wide range of standards such as the Health and Social Care Standards (2017) and the new Core Mental Health Quality Standards and indicators (2024)

Further information about the methodology for adult mental health inpatient services safe delivery of care inspections can be found on our website.

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

The Mental Health Unit within Forth Valley Royal Hospital consists of five wards covering the Stirling, Falkirk and Clackmannanshire area. This includes provision for adult and older adult mental health assessment, dementia specialist treatment and an intensive psychiatric treatment unit.

About this inspection

We carried out an unannounced inspection to the Mental Health Unit in Forth Valley Royal Hospital, NHS Forth Valley on Monday 25 and Tuesday 26 of August 2025 using our safe delivery of care inspection methodology. We inspected the following areas:

- ward 1
- ward 2
- ward 3
- ward 4, and
- ward 5.

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with patients, such as during patient mealtimes
- spoke with patients, visitors and ward staff, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Forth Valley to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Wednesday 24 September 2025, we held a virtual discussion session with key members of NHS Forth Valley staff to discuss the evidence provided and the findings of the inspection.

As part of our inspection process, we also requested to meet with senior managers within NHS Forth Valley on 10 and 24 October to highlight concerns. The purpose of the meetings was to seek further clarity and additional information regarding the content of some patient safety electronic incident reports. These reports detail patient safety incidents reported by staff in the three months prior to the inspection. Our concerns relate to a number of adult support and protection issues and incidents of patients absconding or managing to get on to the garden roof space including at times when on continuous observations.

We will continue to seek assurance in regard to the serious concerns raised at future inspections and through NHS Forth Valley's improvement action plan.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Forth Valley, and particularly all staff at the Mental Health Unit in Forth Valley Royal Hospital for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'.

During the inspection, we observed staff treating patients with care and compassion.

Inspectors observed delivery of care in line with the evidence-based stress and distress model for reducing distressed behaviours in people with dementia.

Mealtimes were well organised with patients being offered a choice of meals.

NHS Forth Valley have a programme of activities specifically designed to improve the physical health of patients throughout the Mental Health Unit.

Patient information was available in a variety of formats including electronically to ensure accessible.

However, areas for improvement identified include ligature assessments that were inconsistently completed and did not align with the NHS Forth Valley ligature risk assessment policy. The healthcare environment was variable with some areas in a poor state of repair.

Improvements are required in the oversight of patient and staff safety incidents, including delays in reviews of adverse events. Themes within patient safety incidents reported by staff in the three months prior to the inspection, include several adult support and protection issues and incidents of patients absconding and managing to get on to the garden roof space.

We observed the impact of low staffing levels on staff training and supervision with low rates of basic life support training and child protection training.

As a result of concerns identified during inspection that required immediate improvement, we wrote to NHS Forth Valley Executive Team on two occasions. On the first occasion to raise concerns regarding adult support and protection, patient safety and governance and assurance and oversight of the Mental Health Unit in Forth Valley Royal Hospital. In response, NHS Forth Valley provided additional assurance of immediate and planned improvement actions taken to address these concerns. Information included in the response is detailed throughout Domain 1.

On the second occasion, to seek assurance on improvement actions related to staff training rates and patient dignity and respect within the adult mixed sex wards. However, NHS Forth Valley could provide only limited assurance of improvement in staff training and of the mitigations put in place to preserve patient dignity and respect within mixed sex areas. The physical environment, within some ward areas,

does not support full mitigation of these risks. We have also shared these concerns with the Mental Welfare Commission.

Other areas for improvement identified include ensuring policies and procedures were up to date and compliance and completion of audits.

What action we expect the NHS board to take after our inspection

This inspection resulted in eight areas of good practice, one recommendation and 19 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Forth Valley to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.scot

Areas of good practice

Domain 2	
1	Inspectors observed staff debriefs happening after an incident within the unit (see page 28).

Domain 4.1	
2	Staff were working hard to deliver compassionate care (see page 31).
3	Ward areas were calm and well organised (see page 31).
4	Patient information was available in a variety of formats including electronically to ensure accessibility (see page 31).
5	Mealtimes were well organised with patients being offered a choice of meals (see page 31).

Domain 6	
6	Inspectors observed respectful interactions between patients and staff (see page 38).
7	NHS Forth Valley have a programme of activities specifically designed to improve the physical health of patients throughout the unit (see page 38).
8	Community meetings are held to allow patients to provide feedback and contribute to their care (see page 38).

Recommendation

Domain 2	
1	NHS Forth Valley should consider the benefit of extending access to reflective session to staff in older adult wards within the Mental Health Unit (see page 28).

Requirements

Domain 1	
1	NHS Forth Valley must ensure safe and effective policies and procedures are in place for all CCTV cameras in use. CCTV cameras must be operated in line with national regulation, guidance and local policy and staff are aware of and apply correct procedures (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 2.7
2	NHS Forth Valley must ensure effective governance and oversight of all necessary staff training to support all staff to safely carry out their roles. This includes, but is not limited to, basic life support, public protection, prevention and management of violence and aggression training and training in relation to specialist admissions (see page 24). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 Criteria 12II & Core Mental Health Standards (2023) Criteria 2.3 & 4.1 and relevant codes of practice of regulated healthcare professions.
3	NHS Forth Valley must demonstrate how it supports the ongoing development of skills and knowledge through adequate supervision and appraisal for staff (see page 24). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 Criteria 12II & Core Mental Health Standards (2023) Criteria 2.3 & 4.1 and relevant codes of practice of regulated healthcare professions.
4	NHS Forth Valley must ensure processes are in place to continue to mitigate the risk of access to the roof in the outdoor space and monitor the impact of any interventions in place (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 5.19
5	NHS Forth Valley must ensure improvement actions are complied with and progressed with agreed timescales to reduce ligature risk identified through significant adverse event reviews and HSE improvement notices (see page 24).

	This will support compliance with: Health and Social Care Standards (2017) Criteria 5.18 & 5.19
6	NHS Forth Valley must ensure effective oversight of ligature risk assessments and any identified risks to ensure these are effectively mitigated (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 5.19 & 4.19 and Quality Assurance Framework (2022) Indicator 2.6 and 4.1
7	NHS Forth Valley must ensure management processes to identify ongoing risk and ensure timely review, oversight and implementation of adverse event improvement actions align with The National Framework for Reviewing and Learning from Adverse Events (2025) (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.24 & 4.19 and The National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (2025)
8	NHS Forth Valley must ensure systems and processes are in place that support the effective identification and mitigation of risk to ensure a safe environment for all patients (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.24, 3.20, 4.1 & 5.19
9	NHS Forth Valley must ensure fire safety doors are maintained in a safe working order that enables safe fire evacuation and reduces the restriction of movement around the older adult wards (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.1 & 5.19 & The Fire Safety (Scotland) Regulations 2006
10	NHS Forth Valley must ensure effective and appropriate governance approval and oversight of policies and procedures that are in place (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.24 & Quality Assurance Framework Criteria 2.6

Domain 2	
11	NHS Forth Valley must ensure that there are clear assurance processes and systems, and these are planned and organised in a way that provides assurance that high quality care is being delivered (see page 28). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.11 & 4.19
12	NHS Forth Valley must ensure there is oversight and consistent application of screening tools to identify the risk of falls or pressure sores across all wards in the Mental Health Unit (see page 28).

	This will support compliance with: Health and Social Care Standards (2017) criteria 1.14 & 4.11

Domain 4.1	
13	NHS Forth Valley must ensure the care environment is in a good state of repair to support effective cleaning and that effective assurance systems are in place to support the reporting of environmental issues and the monitoring of the care environment (see page 31). This will support compliance with: National Infection Prevention and Control Manual (2023), Infection Prevention and Control Standards (2022), Healthcare Associated Infection (HAI) standards (2015) Criterion 8.1 and Health and Social Care Standards (2017) Criteria 5.19 & 5.24
14	NHS Forth Valley must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance (see page 31). This will support compliance with: National Infection Prevention and Control Manual (2023)

Domain 4.3	
15	NHS Forth Valley must ensure there are clear and consistent systems and processes in place for the monitoring and mitigation of any severe and/or recurring staffing risk to support longer term workforce planning (see page 35). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019
16	NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support and monitor wider system oversight, of identified staffing or safety risks within the Mental Health Unit (see page 35). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019
17	NHS Forth Valley must demonstrate how it supports, monitors and reviews the provision of adequate time to lead and resources available to clinical leaders (see page 35). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019

Domain 6	
18	NHS Forth Valley must ensure meaningful activity is consistently provided, including weekends, and that activity plans are completed and updated (see page 38). This will support compliance with: Quality Assurance Framework (2022) Criteria 2.2 & Health and Social Care Standards (2017) Criteria 2.21 and 2.22
19	NHS Forth Valley must ensure that patient's privacy and dignity is maintained, adult support and protection issues are assessed at all times including having appropriate toilet and showering facilities that support dignity and privacy in a mixed sex environment (see page 38). This will support compliance with: Health and Social Care Standards (2017) Criteria 5.1

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We raised concerns with senior managers regarding patient safety and adult support and protection. Additionally, compliance rates with staff mandatory training are low and require improvement.

The Mental Health Unit at Forth Valley Royal Hospital has five mixed sex wards with a total of 89 beds that provide inpatient services for people with mental illness. Ward 1 is an Intensive Psychiatric Care Unit (IPCU), wards 2 and 3 are general adult admission wards, ward 4 is a dementia specialist ward and ward 5 is an admission ward for older adults. Ward 2 provides adult mental health beds for the Clackmannanshire and Stirling area and ward 3 for the Falkirk area. Both older adult wards cover the Forth Valley area. Referrals for admission are through the Mental Health Acute Assessment and Treatment Service. However, admission to the Intensive Psychiatric Care Unit can be through the criminal justice system, the forensic community mental health service and direct referral from outpatients and other mental health wards within NHS Forth Valley.

At the time of inspection, the overall capacity of the wards within the Mental Health Unit was 85.2%. Meaning there were beds available for admission and there was no waiting list for the unit.

An Intensive Psychiatric Care Unit is a locked ward for patients who are in an acute phase of serious mental disorder. There were two additional “surge” beds available in the Intensive Psychiatric Care Unit. These are temporary hospital beds that are added to increase capacity during periods of high demand and are in addition to the funded establishment, within the unit. However, these were not being used at the time of the onsite inspection. The surge beds were in established bed spaces previously used as patient rooms with access to toilet and shower facilities.

Through evidence reviewed we observed that the surge beds had been in use on several occasions within the three months prior to the inspection. We were told by senior managers that the beds are for those who require admission to the Intensive Psychiatric Care Unit and therefore the same criteria and threshold for admission applies. They told us that the decision to use the surge beds is made collaboratively by the clinical nurse manager and consultant. Where the need to utilise surge beds occurs senior managers will review staffing requirements in line with patient acuity to ensure safe staffing and if there is a requirement for additional staffing, staff can be sourced from the nurse bank or through redeploying staff from the other mental health wards within NHS Forth Valley.

The adult acute admission wards have provision for specialist admissions including detoxification from alcohol, perinatal, child and adolescent mental health and for treatment of an eating disorder.

In evidence submitted, we observed guidelines for the planned admission of patients undergoing alcohol detoxification. Care is coordinated through weekly planning meetings between inpatient and substance use services staff and is overseen by the liaison consultant psychiatrist. Training and support are provided by the hospital addiction team. There is also a planned inpatient assisted alcohol withdrawal pathway which is currently awaiting update as it was due for review in March 2024. We were told this delay was due to awaiting the publication of national guidance.

Admission to the Forth Valley Royal Hospital Mental Health Unit with an eating disorder is infrequent with only three admissions in five years. Admission to the Mental Health Unit is only considered if a bed in the regional eating disorder unit is not available and criteria for admission to an acute medical ward is not met. In evidence provided we observed that care is jointly managed by the eating disorder consultant and the inpatient consultant with support from the Mental Health Unit dietician.

NHS Forth Valley does not have a specialist inpatient mental health ward for children and young people. This means that young people aged 16 or 17 requiring admission to a specialist inpatient Mental Health Unit could be temporarily cared for in the ward 3 annex. This annex has provision for one ensuite bedroom for a young person under the care of Child and Adolescent Mental Health Services (CAMHS) and is utilised if an inpatient bed is not immediately available within regional Child and Adolescent Mental Health Services (CAMHS).

The Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice states that a child or young person should only be admitted to an adult ward in exceptional circumstances, for example, where no bed in a child or adolescent ward is immediately or directly available. This is because of the child or young person's vulnerability and the potential impact of an adult environment on the child or young person's mental health. Ward 3 annex also has a mental health perinatal bed. The pathway for admission into these beds all had distinct oversight arrangements and referral criteria.

During our onsite inspection there were no patients aged 16-17 being cared for in this area. However, we were provided with evidence of four admissions of patients aged 16 to 17 in the six months prior to inspection. Best practice guidelines state that hospital managers should advise the Mental Welfare Commission when a young person is admitted to a non-specialist adult ward. Senior managers informed us that these guidelines are followed, and the Mental Welfare Commission were informed following each admission.

Where a patient aged 16 or 17 is admitted to ward 3, their care is planned and overseen by the CAMHS Consultant Psychiatrist and the Intensive Child and Adolescent Mental Health Nursing Team, who attend the ward daily on weekdays.

Senior managers told us that care of the young person is led by ward 3 staff at the weekend in line with the planned care and reviewed by the consultant if necessary. Patients under the age of 18 are also placed on continuous intervention to mitigate the risk within the adult environment. Patients under 16 are admitted to the paediatric ward with support from registered mental health nurses if required. In evidence provided we noted that the standard operating procedure for the intensive CAMHS nursing team is still in draft form with no target completion date.

Inspectors were also told by nursing staff that patients requiring mental health inpatient treatment in the perinatal period may be admitted to the annex in ward 3. The perinatal period spans from conception until the child is one year old. In most circumstances, women in the first postnatal year who require admission to a Mental Health Unit will be admitted to a regional unit where they can be cared for with their baby 24 hours a day. In evidence we observed that there has been one admission of a patient in the perinatal period in the past year. Staff told us that only the patient would be admitted to ward 3, their baby would not be admitted. Senior managers told us that a responsible adult such as a family member or friend would be required to be available when the baby is visiting as staff could not take responsibility for the care of the baby whilst on the unit. Staff also told us that CCTV is available and activated when a baby is in the unit. Staff told us that when a patient is admitted to this bed, signage would be put in place highlighting the use of CCTV in the ward when it is in use. Senior managers told us the CCTV is monitored by security staff in a centralised security office. Limited guidance to support the use of the CCTV in this area is documented within the NHS Forth Valley Inpatient Perinatal Protocol. However, the document is overdue for review from 2023 and the information within the document is limited. NHS Forth Valley could not provide a dedicated CCTV policy, operating procedure or the risk assessment for the use of the CCTV. A requirement has been given to support improvement in this area.

The admission and care of a patient in the perinatal period is planned and overseen by the Perinatal Consultant Psychiatrist and the Perinatal Mental Health Team, who are based in the Mental Health Unit and attend daily on weekdays. Senior managers told us that care of the patient in the perinatal period is led by ward 3 staff at the weekend in line with the planned care and reviewed by the consultant if necessary.

We spoke with senior managers about the challenges in maintaining the knowledge and skills of staff when admission of specialist patients is infrequent. We were provided with evidence of training and support for staff regarding the specialist admissions to the Mental Health Unit. This included training rates on perinatal and child and adolescent mental health eLearning. Within evidence provided only 3% of staff had completed these.

We raised concerns regarding training compliance rates, with senior managers who provided a phased plan of completion of both the essential perinatal and essential CAMHS modules for ward 3 staff with a target completion of 90% by March 2026. In

response to the concerns we raised regarding staff training, we were informed 17% of staff within ward 3 had completed the training following the onsite inspection.

Compliance with child support and protection training was also low. Although senior managers provided an update that 80% of staff have completed public protection eLearning as mandatory training, which includes child protection, specific child support and protection training is not currently required. We noted in evidence that no staff had completed child protection awareness for clinical staff and only two members of staff within the Mental Health Unit had completed child protection for the general workforce.

In response to this, senior managers told us that all ward 3 staff will complete child protection awareness for clinical staff training with further consideration given to embedding additional child protection training as mandatory for all staff within the Mental Health Unit.

Other mandatory training includes basic life support, public protection, fire safety and violence and aggression training. From information provided, compliance across the unit was variable with 75% of staff having completed eLearning in both fire safety and violence and aggression and 60% of staff having completed the practical element of prevention and management of violence and aggression. Recognition of the deteriorating patient during restraint is part of the management of violence and aggression training completed by staff. However, only 21% of staff who work in the Mental Health Unit have completed the eLearning module introduction to adult resuscitation and only 10% have completed the accompanying face to face training. Basic life support training is essential for maintaining a safe and effective healthcare environment and allows staff to act quickly and confidently in critical situations.

In evidence provided we noted that low compliance with mandatory training was discussed at the NHS Forth Valley mental health and learning disability clinical governance working group in July 2025, highlighting current staffing challenges impacting on compliance rates. The impact of staffing shortages and increased acuity on access to training is demonstrated throughout the evidence provided by NHS Forth Valley.

Senior managers told us that they have several strategies to support improved compliance including work to identify protected time for staff on the wards and a phased approach to increasing compliance. The initial focus is on five key priority areas for training to improve compliance. The five priority training areas are infection and prevention control, public protection, violence and aggression, moving and handling and fire safety.

However, basic life support is not included within the top five key priority areas. This is essential to ensure staff have the skills and knowledge to identify and care for the medically deteriorating patient. We raised this with senior managers who, in response, have added basic life support as a priority training area and additional training and support is being offered to ensure staff can safely manage medical emergencies.

Several staff within the unit have been prioritised for basic life support training places in November and December 2025. Additionally, four registered nurses within the unit have been identified as trainers and will deliver training under supervision from NHS Forth Valley resuscitation team until they are confident enough to lead independently. Since 2018 senior charge nurses within the ward have also undertaken simulation training to increase the delivery of this training which includes managing medical emergencies in the psychiatric setting. However, only 14% of staff have completed this training. There have been no staff trained in 2025 due to the unavailability of trainers. Senior managers anticipate that this will recommence from March 2026 when senior charge nurses have completed simulation faculty training.

Whilst we acknowledge NHS Forth Valley's plans in place to address staff training requirements, we remain concerned at the very low levels of training compliance. This concern was included within our letters to senior managers at NHS Forth Valley. NHS Forth Valley must ensure that staff have the opportunity to access training relevant to their role, with effective governance and oversight processes in place to monitor training compliance to ensure staff can maintain the knowledge and skills required to provide safe and effective care. A requirement has been given to support ongoing improvement in this area.

On one ward staff told inspectors that due to low staffing levels they were unable to attend line management supervision, and that annual staff appraisals were overdue. The personal development planning and appraisal process provides a framework for managers to give feedback and support to staff resulting in a more positive work culture. In evidence provided we noted that only 34% of staff across the Mental Health Unit had completed their appraisal. We asked how staff can be supported to maintain skills and knowledge where appraisals are not being completed which may highlight support or training needs. Senior managers told us that appraisal, and the development of personal development plans were a priority for the senior leadership team and work was underway to improve recording of this as well as compliance. A requirement has been given to support improvement in this area.

We asked for details of all patient and staff safety incidents reported in the three months prior to our inspection. There were 516 incidents reported through the electronic incident reporting system across the areas inspected with the majority of incidents categorised as aggressive, violent or challenging behaviour. Inspection findings relating to reported patient safety incidents will be discussed throughout the report.

During our onsite inspection we observed several patients being cared for under continuous intervention supported by staff. Continuous intervention ensures close monitoring and therapeutic engagement with someone who needs intensive support to reduce the risk of harm to themselves or others. Decisions to initiate continuous intervention are based on the risk to the individual and others and should be the least restrictive intervention that maintains safety and promotes recovery in line with the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003. Inspectors

observed ongoing interaction with patients during the inspection. In evidence we were provided with the therapeutic engagement policy and noted that 72% of staff have received training in therapeutic engagement. We were given further evidence that NHS Forth Valley will continue to monitor and report on the completion of therapeutic engagement training. During the inspection we observed that the patients being cared for on continuous intervention had plans in place and patient interaction records were complete and up to date in line with the NHS Forth Valley therapeutic engagement policy.

However, within patient safety incidents reported by staff from the three months prior to the inspection, we observed several incidents of patients absconding while being supported on continuous interventions. This included patients managing to get on to the garden roof space. Although we saw no evidence that patients had been harmed through accessing this roof area, it is a significant patient safety risk. We met with NHS Forth Valley senior managers and wrote to the board to raise serious concerns around patient safety issues including patients absconding via the roof whilst on continuous interventions. In response, NHS Forth Valley have provided detailed improvement plans to address these risks. These include risks and mitigations being communicated through nursing handovers and daily multi-disciplinary huddles to ensure team-wide awareness, shared learning and collective recognition of the need for consistent application of safety measures. Individual risk assessments for each ward have been completed and discussions held with the multi-disciplinary team. In addition to these risk assessments, the risk of patients accessing the roof has been escalated to the corporate risk register and will be subject to greater visibility and scrutiny. Further work includes exploring further risk management interventions in collaboration with NHS Forth Valley estates and facilities and health and safety teams. NHS Forth Valley must ensure processes are in place to continue to mitigate the risk and monitor the impact of any interventions in place to reduce this. A requirement has been given to support improvement in this area.

NHS Forth Valley have an ongoing programme of works in relation to the reduction of identified ligature risks throughout mental health services. A ligature point is a fixture or object in a room where a ligature can be secured. Annual ligature risk assessments are part of an ongoing programme of assurance within NHS Scotland to reduce the number of incidences of self-harm or suicide by identifying potential ligature points and ensuring the controls and mitigations are in place to reduce identified risks.

An incident in the Mental Health Unit in October 2024 resulted in a significant adverse event review and an improvement notice being issued by the Health and Safety Executive regarding ligature point safety in one ward. In response to this NHS Forth Valley produced an action plan for improvements focusing initially on areas identified as high risk within the wards inspected.

We were provided with evidence of a timeline for improvements in response to the Health and Safety Executive notice, including the replacement or amendments to

wardrobes within patients' bedrooms and windows and doors throughout the unit. Completion of the programme of replacement of windows and doors within the Mental Health Unit is estimated to be by January 2027. Senior managers told us that to mitigate the risk of potential ligature points on windows until completion of the work they have locked all the windows, and they are only open when staff are in the room with patients.

Work to amend or replace wardrobes to reduce ligature risk is ongoing with a prototype wardrobe installed in one bedroom in ward 3. Following consideration of this, amendments or replacement of all wardrobes throughout the unit will be confirmed. No timeframe had been identified for this at the time of inspection. A requirement has been given to support improvement in this area.

Senior managers told us that an online training module focusing on the identification of ligature risks is in the final stages of being amended for use with NHS Forth Valley staff. A new clinical mental health risk assessment has been sourced and is currently out for consultation within the clinical governance structures. Following this process an implementation plan will be developed which will commence in November 2025.

The online training module and clinical mental health risk assessment are both being implemented to support the improved identification and mitigation of risk in all wards across the Mental Health Unit. A target for the completion of staff training in ligature risk assessment has been set at 90% of staff trained by April 2026. We were provided with the current ligature risk assessments for all the mental health wards within the unit inspected. Senior managers told us that these were completed by a multidisciplinary team as outlined in the NHS Forth Valley ligature assessment and assurance policy. We observed that although the risk assessments scoring was complete there were inconsistencies in completion with comparable areas in wards being scored differently and current controls not always clear. Action plans were also not completed with progress reports and dates of completion. Within ward level risk registers we observed some controls were highlighted including the use of clinical risk assessments, hourly observation checks and anti-ligature fittings. However, there are inconsistencies with these and with the severity of outcome being assessed as different for each ward.

NHS Forth Valley's ligature assessment and assurance policy states scoring regarding the access to a ligature in mental health wards should always be considered at the highest level of risk and scored accordingly. This was not evident in the ligature risk assessments for any of the wards inspected. These discrepancies highlight that the oversight of ongoing ligature assessments may not provide sufficient assurance around the reduction and mitigation of ligature risks within the Mental Health Unit. A requirement has been given to support improvement in this area.

Staff we spoke with told us that they were concerned about the ongoing risk in relation to the anti-ligature safety beds currently in use throughout the Mental Health Unit. Staff told inspectors of two recent incidents related to the beds in relation to patient and staff safety. We were told of an incident in June 2025, where the patient had dismantled their bed and sustained an injury when climbing inside. Due to the risk of further injury, the bed was removed from the patient's room. Another type of bed was trialled however was subsequently deemed unsuitable. This resulted in a patient sleeping on a mattress on the floor, while other bed options were considered. Whilst we acknowledge the removal of the weighted bed was to support patient safety, we raised concerns with senior managers about the impact of the ongoing use of a mattress on the floor in relation to the patient's comfort and dignity. We asked for this to be addressed as a matter of urgency. Senior managers were able to confirm that a suitable bed was received and in use by early September 2025. Senior managers also confirmed a decision had been made to replace all the weighted beds due to risk of injury from the disassembled bedframe and two models of beds had been ordered and are being trialled in the Mental Health Unit to ensure these were suitable for the environment.

The use of seclusion within mental health inpatient areas should only be considered where there is a clear and identified risk that the patient presents a significant degree of danger to themselves or other people, and the situation cannot be managed more safely or appropriately by any other means. The Mental Welfare Commission suggests that all health boards should have a policy on the use of seclusion whether it's used or not. We asked about the use of seclusion and staff told us that an area within the Intensive Psychiatric Care Unit was being developed to be used for seclusion, however a timeframe for the work had not been agreed. Senior managers told us that there was currently a group working to develop seclusion guidance for NHS Forth Valley. In evidence, we were provided with the draft policy that includes the use of seclusion and long-term segregation. We spoke with senior managers who told us that the final draft has been agreed and will proceed to the mental health and learning disability clinical governance group for review and approval. They confirmed that this process is expected to be completed by February 2026. Within patient safety incident reports reviewed there were no reported incidents relating to seclusion being used.

Patient and staff safety incidents or near misses are recorded on an electronic reporting system and escalated in line with NHS Forth Valley’s guidance for management of adverse and significant events. The level of the review is then determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. The adverse events review group meet weekly and identify incidents which may require referral for Significant Adverse Events Review (SAER) or local management review. We were provided with several adverse event review brief initial review documents. These provide evidence of consideration of risk and potential learning and include issues identified by the families, arrangements for staff support and areas of good practice.

NHS Forth Valley have a local adverse events policy and adverse events guidance for staff within mental health services. The National Framework for Reviewing and Learning from Adverse Events (HIS 2025) is not yet used within NHS Forth Valley but senior managers told us that work is underway to implement this.

We were provided with evidence of incidents being reviewed by the NHS Forth Valley adverse event review group. We also saw in evidence a six-monthly adverse events learning newsletter which details common themes of incidents, outcomes and learning. Senior managers told us that this is cascaded to staff.

However, we observed that several reviews were not carried out or completed within the identified timescale target highlighted for completion. Some initial reviews were carried out up to nine months from the date of the incidents. Within The National Framework for Reviewing and Learning from Adverse Events completion of a level 1 significant adverse event should be completed within 140 days. NHS Forth Valley wide policy aligns with Healthcare Improvement Scotland National Framework timescales. Delays to adverse events reviews can delay systematic learning and improvement within the service and cause ongoing harm and trauma to patients, staff and families. NHS Forth Valley must ensure their current incident report management processes are sufficient to ensure timely review and effective oversight to identify and action any learning. A requirement has been given to support improvement in this area.

Within patient and staff safety incidents reports reviewed we identified two reported incidents of the pinpoint alarm system failing to work on activation. Pinpoint alarms are carried by all staff and are part of a system integrated into the ward environment to allow staff to respond promptly to any emergency situations. Both the alarm company and estates have reviewed the incidents and identified blind spots where the alarms do not activate. There are also additional limitations identified in relation to the infrared sensors when too many staff are involved in an incident. An email had been sent to all staff to highlight risks and mitigations with the pinpoint alarm system, and we were also told that information is shared through the safety brief for non-substantive staff. Additionally senior managers advised inspectors that they are working with the company who provide the alarms to identify and manage actions to reduce the risk of the system not working effectively. As part of this work, we observed evidence of a request in October 2025 to purchase and install additional sensors in the garden areas to ensure the alarms function efficiently in that area. We were provided with evidence that this risk had been escalated through the May inpatient digest for the Mental Health Unit. It was also added to the mental health risk register with initial mitigation of the highlighted risk being disseminated to teams across the mental health estate who currently use the alarm system. The mental health inpatient unit digest is a monthly summary document produced following the Mental Health Unit clinical governance and management group. The summary identifies themes, learning and challenges for discussion and escalation to the mental health and learning disability service clinical governance working group.

Within other patient safety incident reports, we were concerned about incidents regarding significant adult support and protection issues, including sexual safety. Senior managers provided evidence of a clinical risk assessment in place that identified concerns relating to vulnerability. However, there was no explicit prompt to consider sexual safety within the assessment. In our letter to NHS Forth Valley senior management team we raised our concerns and requested more information regarding the oversight of adult support and protection risks. Senior managers were able to provide evidence that requirements in relation to duty of candour had been met. This is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm. Further information on Duty of Candour can be found here.

During discussions senior managers told us that the mitigation of risk around sexual safety for patients was an ongoing challenge due to both the vulnerability of patients, sexual disinhibition and sexualised behaviours being a symptom that people may experience due to significant mental illness or dementia. We were given evidence of a clinical risk assessment used within the Mental Health Unit that identified concerns relating to patient vulnerability. However, this did not contain any explicit prompt to consider sexual safety within the assessment. Additionally, we were provided with further evidence of work to support safe disclosure of sexual harm and guidelines for staff to access the correct support for patients. Patients can be signposted to The Meadows which is a specialist sexual assault response coordination service based near Forth Valley Royal Hospital for those who have experienced trauma. However, we remain concerned that there was a lack of management ownership and oversight of patient safety, support and protection for patients cared for within the Mental Health Unit prior to concerns being raised through the inspection process.

Work around adult support and protection has led to the development of a draft NHS Forth Valley sexual safety policy and the implementation of a sexual safety champion to heighten awareness of risk. The policy will be fully implemented in March 2026. In further evidence provided following the letter of serious concern, senior managers provided us with a several measures to strengthen preventative intervention and awareness of sexual safety for all patients across NHS Forth Valley. These include the addition of an explicit prompt to consider sexual safety in the initial assessment for patients within the Mental Health Unit, a review of past incidents to identify learning and inform improvement work and a review of the current configuration of the wards within the Mental Health Unit. Additionally ongoing improvement work will be informed by the National Sexual Safety Collaborative (2020). These were commissioned by NHS England in 2020 and include standards and guidance to improve sexual safety in mental health and learning disability inpatient areas. We welcome improvement actions taken by NHS Forth Valley in response to concerns we have raised. However, we are not yet assured, that adequate systems and processes were in place prior to this inspection. NHS Forth Valley must ensure that the identification and mitigation of risk is sufficient to ensure a safe environment for all patients and this must include sexual safety. A requirement has been given in relation to this concern.

The Core Mental Health Standards were published in September 2023 and were developed to support individuals, their families and carers to understand what they can expect from mental health services and ensure a person-centred approach is central to the provision of care and treatment. Healthcare Improvement Scotland have collaborated with health boards to complete a baseline local self-assessment to support board areas to start to consider how well they currently implement each area of the standards within working age adult inpatient mental health services. NHS Forth Valley have identified priority areas for improvement and have convened a steering group to lead improvement in the areas highlighted. These include improving engagement with people with lived experience and collection and use of data around patients' outcomes and experiences. An electronic portal will be developed to monitor the progress of implementation.

On the first day of inspection, we observed that fire doors throughout the internal corridors of both older adult wards were in the closed position, and we observed patients with walking aids unable to open them. There was no signage regarding the door being push or pull. On the second day of the onsite inspection, maintenance was being carried out to ensure the fire doors could be kept open unless in the event of a fire. In evidence provided we noted that the fire risk assessments provided for both older adult wards highlighted that the fire doors require regular maintenance due to the locking mechanism. We were told that this is routinely reported to estates who arrange repairs. In evidence provided we observed that the doors are prioritised as urgent and therefore have been repaired on the same or next day after being reported. This has happened five times since January 2025. This also means that there are periods where access to the wider ward is restricted due to the doors being closed. NHS Forth Valley must ensure that the ward is a safe and accessible space for all patients. Senior managers told us that fire doors will be reviewed as part of the estate's lifecycle plan. A requirement has been given to support improvement in this area.

In evidence provided we observed that eight patients were experiencing delayed discharge, with five in the adult wards and three in the older adult areas at the time of inspection. Delayed discharge refers to situations where a patient, who is clinically ready to leave hospital, cannot do so because the necessary care, support, or accommodation is not available. This can occur for various reasons, such as waiting for care home placement, community care arrangements, or adaptations to a home environment. A delay to a patient’s discharge can have a detrimental effect on their wellbeing, such as a loss of confidence or independence. We raised this during our virtual discussion where senior managers explained that patients continue to receive input as outlined in their care plan and would continue to access groups and activities throughout their admission to the Mental Health Unit. They told us of ongoing work in relation to discharge planning with monthly multi-disciplinary meetings with representatives from social work and housing that focus on finding solutions for those who no longer require to be in hospital. In addition, there is work underway to align with acute services, and a dashboard approach is being considered to ensure

accessible accurate information and criteria for delayed discharge is collected and reported consistently across the board area.

Within the evidence provided several policies and procedures were overdue for review within NHS Forth Valley's governance process. These include Intensive Psychiatric Care Unit admission criteria as above, the perinatal inpatient protocol and the alcohol withdrawal pathway which will be discussed later. NHS Forth Valley must ensure current draft and out of date policies and procedures are updated and relevant to the current context in which care is delivered. A requirement has been given to support improvement in this area.

Requirements

Domain 1	
1	NHS Forth Valley must ensure safe and effective policies and procedures are in place for all CCTV cameras in use. CCTV cameras must be operated in line with national regulation, guidance and local policy and staff are aware of and apply correct procedures.
2	NHS Forth Valley must ensure effective governance and oversight of all necessary staff training to support all staff to safely carry out their roles. This includes, but is not limited to, basic life support, public protection, prevention and management of violence and aggression training and training in relation to specialist admissions.
3	NHS Forth Valley must demonstrate how it supports the ongoing development of skills and knowledge through adequate supervision and appraisal for staff.
4	NHS Forth Valley must ensure processes are in place to continue to mitigate the risk of access to the roof in the outdoor space and monitor the impact of any interventions in place.
5	NHS Forth Valley must ensure improvement actions are complied with and progressed with agreed timescales to reduce ligature risk identified through significant adverse event reviews and HSE improvement notices.
6	NHS Forth Valley must ensure effective oversight of ligature risk assessments and any identified risks to ensure these are effectively mitigated.
7	NHS Forth Valley must ensure management processes to identify ongoing risk and ensure timely review, oversight and implementation of adverse event improvement actions align with The National Framework for Reviewing and Learning from Adverse Events (2025).
8	NHS Forth Valley must ensure systems and processes are in place that support the effective identification and mitigation of risk to ensure a safe environment for all patients.
9	NHS Forth Valley must ensure fire safety doors are maintained in a safe working order that enables safe fire evacuation and reduces the restriction of movement around the older adult wards.
10	NHS Forth Valley must ensure effective and appropriate governance approval and oversight of policies and procedures that are in place.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

Staff in the majority of wards inspected told us of good teamwork, sufficient support and open communication within the team and at senior management level. We heard from staff that the use of debriefs following incidents are useful to identify learning and areas for improvement. Compliance with NHS Forth Valley audit schedule was variable.

NHS Forth Valley provided information describing the clinical governance structures in place. NHS Forth Valley has three board level Assurance Committees. These are the Clinical Governance, Staff Governance, and Performance & Resources committees which report quarterly to the NHS Board. Each committee has a distinct remit: the Clinical Governance Committee focuses on clinical risks and quality of care, including issues such as bed pressures and patient safety; the Staff Governance Committee oversees workforce-related risks, including staffing levels and training compliance; and the Performance & Resources Committee monitors service performance, including access and wait times.

Ward level governance and oversight of the Mental Health Unit is delivered through the Mental Health Unit clinical governance meeting and is summarised in the monthly service digest. As described in Domain 1, we were given a copy of the monthly digest for the Mental Health Unit for May 2025. We noted that data on falls, NEWS compliance, staffing and themes around incidents were reported through the monthly digest.

However senior managers told us that the unit clinical governance meeting had not happened for two months prior to the inspection due to workload and staffing issues. This may impact on effective governance and assurance.

Information provided in evidence identified that compliance and completion of audits at ward level was variable. We observed that in May and June 2025 some audits had incomplete submissions with gaps highlighted in the completion of infection control, falls and pressure care audits.

Care plans reviewed by inspectors during the onsite inspection were complete and up to date. However, within information provided the mental health care planning audit in one ward resulted in only 50% compliance. Gaps in assurance processes and low compliance rates may result in a lack of assurance that best practice guidance and standards are being met to support safe delivery of care.

The inspection team found challenges in ensuring sufficient assurance and oversight of audit systems due to the different methods of collating and reporting data. The evidence provided show some of this data being escalated through the clinical governance structure and some being captured in the quarterly care assurance visit reports. Senior managers told us work was underway to streamline reporting as part of the wider safer together collaborative work discussed in Domain 4.1. A requirement

has been given to support improvement in the completion, compliance and oversight of audit and assurance within the Mental Health Unit.

Staff in the majority of wards inspected told us of good teamwork, sufficient support and open communication within the team and at senior management level. However, in one ward we were told that communication to staff was poor, and they did not feel supported by clinical managers. We raised this with senior managers who told us of ongoing work to support the staff within the ward. Through evidence provided, we observed this was the ward that has reported an increase in patient acuity and incidences of violence and aggression in the six months prior to inspection which was impacting on staff morale. Senior managers told us a member of ward staff has now undertaken the train the trainer course for violence and aggression and will support the staff to build confidence in recognising triggers for violence and de-escalation skills. We also observed in evidence that a new senior charge nurse and deputy charge nurse were also in post and had a focus on reintroducing staff meetings and building relationships within the multi-disciplinary team to support staff wellbeing.

Staff within the adult wards in the Mental Health Unit also had the opportunity to attend monthly reflective practice sessions with the psychology team and lead nurse. Senior managers told us that uptake was good with up to six members of staff attending each session. The frequency was increased if there are increased challenges on the wards. During inspection staff also told us that when they had time to attend, it was valuable. In evidence provided we observed very positive feedback from staff who attended the sessions. However, we observed that the sessions were only available to staff in the adult wards. This means that staff who work in the older adult wards do not have the opportunity to attend. A recommendation has been made to support increased access to the sessions.

In one ward we were given evidence of a debrief template for both staff and patients following incidents such as violence and aggression where restraint was used. Conducting a post-incident debrief helps identify and address any harm to patients or staff, ongoing risks, and the emotional impact on patients and staff. It also identifies what was helpful and any learning points highlighted by staff and patients. Staff told us it would not always be appropriate to carry out a debrief with a patient immediately after an incident and this would be carried out at a suitable time to meet the patients' needs. Staff debriefs allow ward level discussion on incidents in relation to what went well and any areas for improvement. During the inspection we observed a staff debrief happening following an incident. This is good practice.

Inspectors observed an inconsistent approach to the assessment of patients who may be at risk of a fall or pressure area damage across the Mental Health Unit. We observed falls care plans in place in older adult wards. However, staff we spoke with in adult wards described using professional judgement to assess the need to complete pressure care or falls risk assessments. As discussed earlier in this report within incident reports reviewed falls were among the highest reported incidents. Within this

information, in only one incident a post falls review was completed, and a falls bundle was recommended in feedback following review of several incidents.

In relation to pressure area care, the lack of initial assessment in the adult wards is not in line with the NHS Forth Valley pressure ulcer policy for prevention, assessment and management that states that every patient admitted to Forth Valley Royal Hospital should have a formal pressure area risk assessment.

We raised the lack of initial falls and pressure area assessments in adult wards with senior managers who told us that concerns around physical health or frailty in relation to increased risk of falls or pressure damage would be highlighted in the initial physical health assessment on admission. However, as risk of falls or pressure damage are not explicitly highlighted within the physical health assessment patients who are at risk may not be identified.

In incident reports reviewed we identified one incident in which a patient who had been recently transferred from another NHS Forth Valley hospital had pressure damage. This was identified during personal care several days after admission. However, no pressure area risk assessment had been carried out for the patient on admission to the ward in the Mental Health Unit despite information within the handover that this was an ongoing care need. We noted it took one week from admission for an initial physical assessment to take place. Following review, the patient was given increased pain relief and referred to the tissue viability nursing service. We raised our concern with senior managers about the delay in identifying and assessing the pressure damage and the implementation of a care plan to ensure sufficient pain relief and treatment. They provided assurance they had already taken action, following submission of the staff member recording the incident report. The patients care had been reviewed and described a plan for increased scrutiny to ensure risk assessments are undertaken for all older adults being admitted to the Mental Health Unit on admission. We were provided with a new prevention pressure area policy which has been developed, and senior managers explained the implementation of this policy will be supported by the practice development team. We remain concerned about the lack of oversight of patient care, and effective risk assessment in place, to ensure patients at risk of falls or pressure damage within the adult wards in the Mental Health Unit are being identified on admission. A requirement has been given to support improvement in this area.

NHS Forth Valley provided a programme of induction which includes the Registered Mental Health Nurse Induction and preceptorship passport. This is a comprehensive document that details completion of mandatory and role specific training and ongoing competency and skills attainment. The demonstration of competency and the completion of evidence is signed off by a designated preceptor. Staff told us these are useful tools to ensure new staff are inducted to the service safely.

Area of good practice

Domain 2	
1	Inspectors observed staff debriefs happening after an incident within the unit.

Recommendation

Domain 2	
1	NHS Forth Valley should consider the benefit of extending access to reflective session to staff in older adult wards within the Mental Health Unit.

Requirements

Domain 2	
11	NHS Forth Valley must ensure that there are clear assurance processes and systems, and these are planned and organised in a way that provides assurance that high quality care is being delivered.
12	NHS Forth Valley must ensure there is oversight and consistent application of screening tools to identify the risk of falls or pressure sores across all wards in the Mental Health Unit.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

We observed warm and caring interactions with patients with evidence-based interventions being carried out. However, the healthcare environment, within several areas was in poor condition and in need of repair to ensure a safe and clean environment.

All wards inspected, although busy, were calm and organised throughout the inspection. NHS Forth Valley uses electronic care documentation. The majority of documentation that inspectors were able to review demonstrated a person-centred approach to care and was up to date. We observed evidence of patient and carer involvement and when patients were not involved the reason for this was documented.

We observed staff treating patients with care and compassion, showing dignity and respect and communicating clearly and sensitively. Inspectors spoke with patients who were mainly positive about the care they received.

Within the older adult wards, inspectors observed that care and comfort rounds were up to date and complete. Care and comfort rounds are a structured process that involves checks to address issues and identify care needs proactively. In the adult wards hourly improving observational practice (IOP) charts were completed which identify the whereabouts of all patients and encouraged brief interaction to allow opportunity for early recognition of deteriorating patients using a traffic light system

outlined in the therapeutic engagement policy. In evidence provided we observed that the hourly checks were able to identify risk and facilitate interventions to reduce or prevent harm.

NEWS2 charts were completed as prescribed and in one ward a board identifying the frequency of physical observations for each patient was displayed in the staff office. NEWS2 charts are used to record a patient's physiological parameters such as pulse and blood pressure and will alert staff if a patient is at risk of deterioration. We noted in evidence that in June 2025 compliance with the weekly NEWS2 audit was around 90% following a sustained improvement over the preceding year.

The safer together collaborative provides a framework for improvement designed to promote safe, reliable healthcare across NHS Forth Valley. Within the Mental Health Unit, we saw evidence of work to improve therapeutic activity with several wards having a full timetable of activity. This work is ongoing and part of a wider range of initiatives across mental health and learning disability services. The aim within the Mental Health Unit is to reduce incidents of violence and aggression by up to 30% with the increase of therapeutic activity across the unit. Additionally, evidence provided showed that although falls and violence and aggression were among the highest reported incidents, a reduction in falls throughout the unit was in line with the increase in therapeutic activity. Inspectors observed that in one area information relating to the outcomes were displayed and showed a reduction in incidents of violence and aggression. However, inspectors observed that activities in one ward were limited during the inspection. This is discussed further in Domain 6.

The Mental Health (Care and Treatment) (Scotland) Act 2003 emphasises patient rights, participation in decision-making, and person-centred care. Inspectors could identify legal status clearly.

Patient information was available within wards. Some used QR codes to provide patients with ward information and self-help resources for dealing with mental health concerns. The Mental Health (Care and Treatment) Act 2003 also highlights that every person with a mental illness should have the right to access independent advocacy services. Information on accessing advocacy services was readily available throughout the unit. Mental health advocacy provides independent support for individuals with mental health needs.

Inspectors observed a dementia friendly environment in ward 4 which provides specialist care and treatment for those with the condition. A dementia-friendly environment is designed to support individuals with dementia by minimizing confusion and enhancing their ability to navigate and function within their surroundings with clear signage on rooms and work done to improve the sitting room and therapy room. However, as discussed earlier in Domain 1 a requirement has also been given in relation to maintaining the fire doors to ensure access to the wider ward is not restricted.

Mealtimes were well organised, and a choice of food was offered. Many patients attended the dining room, but some patients elected to stay in their rooms. We saw that the staff on the ward went round each room and checked each patient to ensure they were attended to.

During the inspection patient care equipment was clean and ready for use. Storerooms were tidy and well organised. The hospital environment appeared clean. However, we observed evidence of considerable wear and tear throughout the Mental Health Unit, for example torn flooring in main ward corridor areas which was covered in tape, and peeling and damaged ensuite walls and floors. Damage to healthcare environments can impact effective cleaning and create a risk that a patient or member of staff could be injured.

In one patient bedroom that was not in use, we observed significant damage to the ensuite shower area. The wall was damaged with the covering peeled off and black marking over the shower wall. We raised our concerns with the senior managers immediately and requested evidence that this was actioned as a matter of urgency. The update by senior managers provided assurance that the work had been completed and the room was suitable for use.

Staff we spoke with told inspectors of the process of identifying repairs to estates. Forth Valley Royal Hospital is a private finance initiative building and is therefore maintained by a private maintenance contractor. Staff contact a helpdesk to request repairs and the responsibility for ensuring that issues are reported and followed up lies primarily with the Senior Charge Nurse. However, there is currently no formal oversight at ward level to ensure that all repair jobs have been logged, reported, or completed. Senior managers told us that reliance on individual diligence can lead to inconsistencies in tracking and resolution. Staff also told us that although urgent requests are mainly actioned timeously, those prioritised as less than urgent are often delayed. A requirement has been given to support improvement in this area.

Standard infection control precautions such as linen, waste and sharps management minimise the risk of cross infection and must be consistently practiced by all staff. Patients personal clothing was laundered on site and all other linen was processed at the hospital laundry. We observed both linen and waste were managed in line with the national infection prevention and control manual. Sharps boxes were all closed and marked with dates and names and not over filled. Alcohol based rub was available in locked areas of the wards due to risk to patients, and staff were seen using this appropriately.

Inspectors spoke with domestic staff who told us that they are able to complete their duties within their shift time and have sufficient access to supplies to clean their clinical areas. They also told inspectors they felt supported by their supervisor and were happy to raise any concerns to the supervisor or nursing staff. If they are unable to access a patient room this is escalated directly to the nursing team.

Wards inspected had infrequently used water outlets that require to be flushed twice weekly. In one ward nursing staff are required to do this on a Tuesday and Thursday and there was a process in place to record this. However, this was not consistent across the wards and we noted in one ward that staff were unsure who was responsible for this. We raised this with managers who provided assurance that a review of infrequently used outlets had been completed and any identified will be flushed twice weekly by staff and recorded appropriately. This will be monitored as part of the senior charge nurse monthly check. A requirement has been given to support ongoing improvement in this area.

Areas of good practice

Domain 4.1	
2	Staff were working hard to deliver compassionate care.
3	Ward areas were calm and well organised.
4	Patient information was available in a variety of formats including electronically to ensure accessibility.
5	Mealtimes were well organised with patients being offered a choice of meals.

Requirements

Domain 4.1	
13	NHS Forth Valley must ensure the care environment is in a good state of repair to support effective cleaning and that effective assurance systems are in place to support the reporting of environmental issues and the monitoring of the care environment.
14	NHS Forth Valley must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Within the majority of wards, we observed good teamwork with most staff described feeling supported. However, staff raised concerns regarding the impact of ongoing staffing challenges on their ability to deliver safe and effective care.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to apply the Common Staffing Method (CSM), which includes a staffing level tool run and requires this to be applied rigorously and consistently. The application of the common staffing method and staffing level tool supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care. As part of evidence, we observed staffing level tool runs had been undertaken in March 2025.

We were provided with the reports generated following the staffing tool run. This showed that patient acuity was considered high during the tool run period and recommended that the new mental health and learning disability tool is run in November 2025. Senior managers told us that additional training and support for staff in the use of this and the professional judgment tool and Safe Care will be rolled out from October 2025.

NHS Forth Valley use Safe Care to monitor real time staffing across the Mental Health Unit. Safe Care is an electronic staffing system which reports real time staffing requirements based on roster demand or patient care needs. This provides a traffic light system with red areas having the highest shortfall of staff available to meet patients' needs. This enables informed decisions to be made when deploying staff to help mitigate risk. This system considers the acuity of the patients versus available staffing numbers. It also allows for professional judgement to be made in terms of required staffing in relation to patient acuity.

Within evidence reviewed nursing staffing levels were consistently reported as amber using the RAGG (red, amber, grey and green) system within Safe Care. With green being optimal, amber the minimum safe staffing levels, and red indicating significant staffing shortages or skill mix. Inspectors onsite observed than when amber status was declared for all five inpatient ward areas, the outstanding bank shift requested for the upcoming shift were withdrawn meaning staffing levels would be unlikely to achieve green. Evidence reviewed demonstrated amber status for over 80% of the time for the last year. Staff we spoke with described staffing levels dropping down to red levels due to breaks or staff escorting patients off the ward for appointments or treatment. Inspectors observed staff moving between wards to provide cover for breaks, appointment or clinical incidents which required a temporary increase in staff numbers. While we recognise that this does not necessarily result in increased risk, NHS Forth Valley did not appear to have a formal process for the monitoring of this. A requirement has been given to support improvement in this area.

On one ward inspected staff we spoke with told us staffing levels often did not reflect the acuity of the ward. For example, the established staffing levels did not reflect the number of staff sometimes required to assist with personal care safely or to deal with incidents of violence and aggression. Staff throughout the unit also voiced concern regarding the ongoing staffing challenges and the impact of these on delivering care. As previously mentioned, some staff raised concerns regarding staffing numbers in relation to being able to attend training. However, staff we spoke with told us they are comfortable escalating any concerns with staffing and feel that they are generally supported by managers to do this.

There were five incidents in the three months prior to our inspection where staff reported low levels of staffing or inappropriate skill mix that mainly related to night shift. This led to delays in observational checks and staff getting breaks from the ward. We also observed that staff engagement and feedback provided in evidence highlighted areas where staff feel the low staffing levels have impacted on their ability

to deliver safe and effective care. In one ward staff said that timely completion of care documentation was a challenge although inspectors did not see evidence of this onsite. Attendance at supervision and protected time to attend training can be challenging due to clinical activity and staffing levels. In addition to this we observed in evidence that staff had highlighted difficulty accessing breaks in time. We noted that these incidents were all reviewed and staff were given a response to concerns through the incident reporting system.

We asked senior managers about the impact of low staffing and the use of Safe Care that confirmed consistent amber levels of staffing. They told us that although the Safe Care system has been in place for some time, they felt that assessment of safe staffing levels may not reflect the acuity in the wards. The introduction of a pilot of a dependency calculator in one ward in July 2025 is ongoing as part of work to review and realign categorisation of risk in relation to safe care. This is being supported by NHS Forth Valley staffing team.

Inspectors attended two Mental Health Unit site specific safety huddles and one wider service staffing huddle that included input from staff in Bellsdyke Hospital, Lochview and the mental health acute assessment and treatment service. Staffing requirements are reviewed at the huddles and actions are taken to mitigate risk such as movement of staff within the Mental Health Unit and from Bellsdyke hospital. Substantive staff, mainly healthcare support workers from NHS Forth Valley staff bank, are also utilised. We observed inclusive and open conversations with highlighted areas of concerns and risk regarding multi discipline staffing and acuity discussed with mitigations put in place where areas of concerns were highlighted. We observed actions taken to reduce staffing risks such as the movement of staff across the sites.

Senior managers also told us of a whole system call twice weekly that is attended by representatives from mental health services from throughout the board. The aim of the call is to assess the operational status across NHS Forth Valley enabling proactive management of any service pressures. However, there are no formal written note of outcomes or action.

Forth Valley Royal Hospital have an acute wide daily site huddle, however the Mental Health Unit was not represented at this. This is a potential missed opportunity to provide a daily wider system oversight of staffing and safety risks within the Mental Health Unit. Following our inspection senior managers provided confirmation that actions were being taken to improve the monitoring of attendance at site wide safety huddles and the recording of actions or issues raised during huddles. NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support and monitor wider system oversight of identified staffing or safety risks within the Mental Health Unit. This includes accurate recording of any escalation, mitigation/inability to mitigate and communication of outcomes with all relevant clinical teams. A requirement has been given to support improvement in this area.

Workforce data submitted by NHS Forth Valley for June 2025 demonstrates an overall nursing vacancy rate of 12.5% within the Mental Health Unit at Forth Valley Royal Hospital and a total sickness absence rate of 16.6%. We consider a high vacancy rate to be greater than 10% with the aim to achieve a sickness absence rate of 4% or less.

At ward level, senior charge nurses oversee daily staffing and deployment, to support skill mix across the Mental Health Unit. Clinical nurse managers monitor staffing trends, bank usage, and compliance with mandatory training. Concerns are escalated through operational governance structures to inform workforce planning and board-level oversight via the workforce governance group. However, as described earlier in this report, staff training compliance is significantly lower than expected, indicating that this system of monitoring has not been effective.

We asked senior managers how they manage workforce requirements considering the high sickness and vacancy rates within nursing staff. They told us that in relation to vacancies within the unit they are in the process of recruiting newly qualified nurses with 10 nurses accepting positions within the Mental Health Unit. Additionally, the process of recruiting health care support workers is underway with 13 whole time equivalent posts being sought. The current forecast will lead to over recruitment and may contribute to increased staffing throughout the Mental Health Unit in the longer term. We noted in Domain 2 that there is a comprehensive induction process for new staff.

We asked senior managers about the high 16.6% sickness absence rate and how staff are supported back to work after a period of sickness. In evidence submitted we observed that management of absence is led by the senior charge nurse with regular contact maintained with absent staff and oversight through managerial supervision with the clinical nurse manager. We also noted in evidence a trauma informed approach to staff support across NHS Forth Valley as part of their Workforce Wellbeing Plan which enables managers to be confident in supporting staff wellbeing. This is supported by a human resource advisor linked to the Mental Health Unit. Senior managers told us that they are currently undertaking a deep dive into sickness absence, and a vacancy panel has been established to address long term sickness and develop effective ways of supporting people back to work.

Time to lead is a legislative requirement under the Health Care Staffing (Scotland) Act (2019). This is to enable clinical leaders to provide the delivery of safe, high quality and person-centred healthcare. Staff in the wards told us that the senior charge nurses were regularly counted in numbers due to low staffing. In evidence provided we observed that ongoing pressures in managing ward demands and capacity continue to require both senior charge nurses and deputy charge nurses to work unplanned clinical hours to maintain safe staffing levels across all wards in the unit.

Time to lead is monitored by the clinical nurse manager and escalated through the workforce governance framework although we received no information about how often senior charge nurses are unable to fulfil managerial duties due to clinical acuity

and low staffing. NHS Forth Valley must ensure that senior nursing staff are given sufficient time to lead and this continues to be monitored and addressed. A requirement has been given to support improvement in this area.

Requirements

Domain 4.3	
15	NHS Forth Valley must ensure there are clear and consistent systems and processes in place for the monitoring and mitigation of any severe and/or recurring staffing risk to support longer term workforce planning.
16	NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support and monitor wider system oversight, of identified staffing or safety risks within the Mental Health Unit.
17	NHS Forth Valley must demonstrate how it supports, monitors and reviews the provision of adequate time to lead and resources available to clinical leaders.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

We observed patients treated with dignity and respect. Patients we spoke with were mainly positive about their experience. Information and feedback mechanisms for patients and carers were readily available throughout the Mental Health Unit. However shared toilet and bathroom facilities may impact on patients' privacy and dignity.

Inspectors observed that patients were treated with dignity and respect by staff. We observed warm and respectful interactions between patients and staff and person-centred interactions based on best practice models for dealing with distressed behaviour.

In one ward we observed a patient who was bare footed and in a hospital gown. Inspectors spoke with staff at the time of inspection who explained that this patient became very distressed when donning clothes. They told us of the challenges in maintaining dignity and implementation of a specific person-centred care plan to reduce distress but maintain dignity if the patient is unwilling or unable to get fully dressed. Inspectors observed that all other patients appeared clean and comfortable in their own clothes.

Stress and distress is an evidence-based approach for dealing with stressed and distressed behaviours that aims to improve the experience and outcomes of people living with dementia. Inspectors saw evidence that this approach, including the use of psychological formulation was used with patients in the older adult wards. The development of this had been supported by a psychology assistant assigned to work with patients in ward 4. However, nursing staff explained to inspectors that this resource was no longer available as the temporary post has come to an end. Staff

were concerned that the application of the stress and distress model would not continue due to staffing levels and insufficient numbers of staff being trained to support the approach. We observed in evidence that only six members of staff were trained in stress and distress at the time of inspection, including the senior charge nurse. This means that application of the model and in particular development of formulations in relation to stressed behaviour will be challenging. In further evidence provided we were given dates of further training and details of actions to support the ongoing implementation of the stress and distress model across inpatient and community services for those living with dementia. In ward 4 this includes weekly support from a clinical psychologist, increased capacity due to newly qualified nurse intake and identified periods of time dedicated to completion of the formulations.

We were given evidence of several quality improvement projects being undertaken. These included a project completed recently regarding the redesign of a sitting room for people with dementia in one ward. This incorporated reminiscence therapy, improved acoustics and softer lighting and colour palette. Evaluation of this showed a decrease in the number of falls and incidents of violence and aggression when compared to a comparable period prior to the introduction of the new sitting room.

Each ward within the Mental Health Unit had access to an enclosed outdoor area which appeared well maintained. As mentioned in Domain 1, the garden areas have identified risks around patients accessing the roof area. Senior managers told us they are working to mitigate this by employing environmental strategies such as limiting direct access from certain areas but also identifying if someone is at risk of absconding and requires additional support from staff.

People who experience significant mental health problems are at a considerably higher risk of developing physical health problems than the general population. Inspectors observed evidence of activities focused on improving physical health including body boost bingo in the older adult wards and a physiotherapy led programme of activities including boxing and gym access in the adult wards.

The provision of meaningful activity on mental health wards is said to increase social connectedness, improve psychological wellbeing and is essential to promote wellbeing and recovery. We observed evidence that activity coordinators, occupational therapy staff, nursing staff and physiotherapy are all involved in planning and delivering activities throughout the unit.

Inspectors spoke with the activities coordinators on one ward who were able to evidence the timetable of events for the upcoming week. This contained activities designed to promote better physical health such as walks and access to a gym in the unit and others which were aimed at improving mental health such as emotional regulation and better understanding of triggers which may impact upon their mental health. However, there was limited input for meaningful activities at weekends on some wards.

Additionally, inspectors observed that on one ward limited meaningful activity was planned and we were told by staff that this was generally led by nurses and dependent on staffing levels. The only activity planned was boost bingo and a weekly visit from a therapet. The focus on dementia-reducing stress and distress improvement programme is a collaboration between Healthcare Improvement Scotland, the Care Inspectorate and NHS Education for Scotland and highlights that people with dementia benefit from an environment which enables a wide range of meaningful activity in line with person-centred care. We raised this with senior managers who told us that in addition to planned activities, the approach to therapeutic activity includes unplanned person-centred activities that are guided in part by the 'getting to know me' documents. These are completed by families and patients where possible to help tailor engagement and reduce stressed and distressed behaviour. A requirement has been given to support improvement in this area.

The unit had recently become a no smoking zone with nursing and occupational therapy staff providing smoking cessation support to patients. However, the activity coordinators told us that the smoking ban has impacted on the attendance at activities as people chose to leave the grounds and smoke if able rather than attend activities.

We observed that community meetings were part of planned activities to ensure patients have an opportunity to provide feedback and ideas for improvement within the wards.

We also observed feedback boards in one ward that included 'you said we did' sections to highlight any improvements made following feedback from patients or carers. On boards throughout the wards, we also observed QR coded feedback forms which patients and carers can access and use to provide feedback on care and treatment.

We spoke with several patients who gave positive feedback about their care. They stated that they had good relationships with staff and were able to contribute to their care planning. One person did feel they weren't always listened to. We fed this back to staff.

In the adult mixed sex wards some rooms do not have ensuite facilities which means patients are required to use a shared communal toilet and shower. We spoke with one patient who stated they felt it was undignified sharing toilet and shower facilities with other patients. Inspectors fed this back to ward staff during the inspection. We raised concerns regarding mixed sex toilet and shower facilities with senior managers. We were advised there is not a risk assessment in relation to patient placement in the mixed sex wards and managers told us professional judgement and the needs of the individual were considered when patients were admitted to the unit. In response to concerns raised, we were provided with plans to reconfigure gender specific areas within the adult admission wards. However, although mitigations to preserve patient dignity and respect within mixed sex area were provided, the physical environment within some ward areas does not support full mitigation of these risks. The impact on

patient dignity and respect should be considered as a matter of urgency, along with any potential risk with regards to adult support and protection concerns, highlighted throughout this inspection. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 6	
6	Inspectors observed respectful interactions between patients and staff.
7	NHS Forth Valley have a programme of activities specifically designed to improve the physical health of patients throughout the unit.
8	Community meetings are held to allow patients to provide feedback and contribute to their care.

Requirements

Domain 6	
18	NHS Forth Valley must ensure meaningful activity is consistently provided, including weekends, and that activity plans are completed and updated.
19	NHS Forth Valley must ensure that patient's privacy and dignity is maintained, adult support and protection issues are assessed at all times including having appropriate toilet and showering facilities that support dignity and privacy in a mixed sex environment.

Appendix 1 – List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Core Mental Health Quality Standard (Scottish Government, September 2023)
- Delivering Together for a Stronger Nursing and Midwifery Workforce (Scottish Government, February 2025)
- Fire Scotland Act (Acts of the Scottish Parliament, 2005)
- Food, fluid and nutritional care standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, November 2014)
- From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care (Healthcare Improvement Scotland, January 2019)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, May 2022)
- Mental Health (Care and Treatment) (Scotland) Act (Acts of the Scottish Parliament, 2003)
- National Infection Prevention and Control Manual (NHS National Services Scotland, January 2024)
- Healthcare Improvement Scotland and Scottish Government: operating framework (Healthcare Improvement Scotland, November 2022)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- Rights, risks, and freedom to limits (Mental Welfare Commission, March 2021)
- Staff governance COVID-19 guidance for staff and managers (NHS Scotland, August 2023)
- Standards for student supervision and assessment (Nursing & Midwifery Council, April 2023)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)

- The quality assurance system and framework – Healthcare Improvement Scotland (Healthcare Improvement Scotland, September 2022)

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