Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 17, St John's Hospital, Livingston, EH54 6PP

Date of visit: 10 December 2019

Where we visited

Ward 17 is the adult acute admission service, covering the West Lothian area of NHS Lothian. The ward is based on the second floor at St John's Hospital, Livingston and has 24 beds, offering mixed-sex accommodation comprising of four dormitories and six single rooms.

We last visited this service on the 17 December 2018 and made recommendations about person-centred goals, and the recording of advance statements.

On the day of this visit we wanted to follow up on the previous recommendations and also look at the environmental changes. Since our last visit the ward has undergone improvements in relation to anti-ligature work and has been refurbished.

Who we met with

We met with, and reviewed the care and treatment of, nine patients. As this was an unannounced visit, no carers or relatives had been advised that we were visiting ward 17 and on the day of the visit there were none available to meet with us.

We also spoke with members of the nursing team, the senior charge nurse (SCN), the clinical director for psychiatry, the clinical nurse manager, and the occupational therapist (OT).

Commission visitors

Ian Cairns, Social Work Officer

Philip Grieve, Nursing Officer

Claire Lamza, Nursing Officer

What people told us and what we found

Those that we spoke to described their care and treatment whilst in the ward in positive terms. We heard that they found different members of the multi-professional team provided them with help in their recovery. We were told that when working with their psychiatrists, individuals found them to be supportive in finding common ground in terms of their medication and time off ward. We heard that the nursing staff would come and ask patients about their mental health needs and supported them in addressing concerns that were important to them.

Those that we met with explained that there was a good range of activities available, and that the help from OTs was beneficial in terms of improving their mental health and maintaining life skills. We were advised that, for some, an admission to hospital was not a choice that they would have made, and that they had been resistant to the idea, but since being admitted, they felt that their in-patient stay had been beneficial in terms of their mental state and had given them hope.

In speaking with the clinical staff, we heard about developments in the provision of mental health in West Lothian. The implementation of the re-designed community mental health service is scheduled for early 2020, and it is anticipated that this will improve transitions in care and with the patient's journey. For Ward 17, there is now additional psychiatry input, along with staff training in psycho-social interventions, the decider skills, and awareness sessions on personality disorder. The ward continues to accommodate patients from the City of Edinburgh, who would routinely be in-patients at the Royal Edinburgh Hospital, and have developed a way of supporting this group of patients while they are cared for out of their local area.

We noted that the environment has benefited from a refurbishment of the main areas, including the corridors, the lounge and dining area, and patient areas where there were ligature points. The ward looks fresh, contemporary and spacious, and all that we spoke to commented positively about the changes.

Care, treatment, support and participation

We reviewed the interventions and evaluation of care in each patient's file, which is currently recorded on both a paper-based version, as well as an electronic system, TrakCare. We were advised that in future, there will be a single process for this. In the meantime, the patient's care plan is written, while the day-to-day progress notes, the multidisciplinary review, and legal paperwork are electronically kept. Some key documents, such as the patient's time off ward are kept in both paper and electronic formats.

We did find that there was clearly defined one-to-one sessions with nursing staff, reviews with medical staff, timely assessments and input from psychology, OTand dietetics, where a referral had been made. On TrakCare, we found the weekly multidisciplinary team (MDT) meeting provided a clear record of the discussion and review of patients legal and pass status, their mental state, as well as a working diagnosis and the plan, with actions that were evidenced at subsequent reviews.

However, we also found that having both paper and electronics records created different, and at times conflicting information to be stored in each system. We noted that there were reviews

of care that were routinely recorded on the electronic system that were not then updated where there was a corresponding paper format, such as the pass plans and the risk assessments. We also found variations in the formats of the documents with some paper-based care plans being developed in other clinical settings, such as the intensive psychiatric care unit (IPCU), and then not being updated while the patient was in the acute admission environment of Ward 17.

In some care files, there was detailed information on early warning signs for patients, and in others, a useful integrated care pathway (ICP) document that was comprehensive, but these were not available in all patients' records. We had previously recommended that there should be a care plan that had meaningful goals; we found that these still lacked definition and personalisation in terms of what interventions were currently being provided for each patient, what specific approaches were benefiting the patient, and how the patient was improving as a result of the care and treatment provided.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Recommendation 1:
Managers should review the existing system for care files and develop a cohesive set of documents for the acute in patient ward that reflect person-centred care and that are routinely audited.

Use of mental health and incapacity legislation

On the day of our visit, for those patients who were being treated under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), we found all of the relevant paperwork in the care files and on the electronic system. We also saw that consent to treatment certificates (T2) or certificates authorising treatment (T3) were in place, and that, with the exception of one patient, prescribed medication was authorised appropriately. We discussed this with the clinical director for psychiatry at the end of the visit. We were advised that there is a regular audit programme that reviews the use of T2 and T3 forms and at times there are a number of medical staff involved. This can result in additional prescribing of medication that is not authorised by the relevant certificates has occurred.

For those patients in the ward who were under specified persons guidance, sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be put in place. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

Our specified persons good practice guidance is available on our website at:

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

We found that, while there was a record of a patient being specified noted on the electronic system and reviewed at the MDT, the RES 1 form was not stored with the patient's care file. This was highlighted to the clinical team at the time of the visit.

There were no patients who were under the Adults with Incapacity (Scotland) Act 2000

Recommendation 2:
Managers should ensure authorised procedures under the Mental Health Act are followed appropriately.

Rights and restrictions

The entrance to Ward 17 is open. There is a central observation point for nursing staff who have a clear line of sight for those patients who are able to come and go from the unit. We found that where a patient's time off the ward was recorded on a paper version and stored in their care files, the reviews were noted electronically at the MDT meeting. We also found that this information was, in some files, inconsistent, with the electronic reviews not being updated on the paper version. We were concerned that this could create the risk of patients being restricted to the ward as a result of staff not having the most up-to-date information.

We noted that risk assessments were individualised and these were reviewed and updated regularly; although again, this was not always evidenced in the paper copy.

Recommendation 3:
Managers should ensure that the information about a patient's risks and time off ward is accurately reflected in their care file.

Those that we spoke to on the day were aware of how access to advocacy and legal advice, and, where relevant, this was recorded in the patient's file. We noted that there was still limited information about advance statements available for patients and discussed with clinical staff that NHS Lothian has developed a standard operating procedure (SOP) about advance statements, which would be useful in promoting patients' uptake of these.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We have previously commented positively on the range and diversity of activities and on the opportunities for patients to engage in occupation. This continues to be the case with patients able to access one-to-one sessions with dedicated activity co-ordinators during the week and at the weekend. In addition to this, there are assessments and input from occupational therapists (OT) and OT assistants, as well as sessions with psychology, with future plans to develop additional psychological interventions.

We heard from patients that they found the range of activities to be beneficial in supporting their engagement with staff and in improving their skills and motivation. There is access to a gym, with input provided from external community staff. This could be made available more

frequently if there was an opportunity to train clinical staff, in supporting patients to access the equipment. We discussed this with the SCN on the day of the visit.

The physical environment

Since our last visit, the main corridor throughout the ward has been improved with new floor coverings. All of the doors have been updated, the ward had been freshly painted, and the windows and ceilings in main day areas have been upgraded. Privacy screens on patient bedroom doors incorporate local scenes, and add some interesting artwork, with plans to develop this further throughout. The ward looks modern and bright, with the required safety aspects from the anti-ligature works now incorporated into the new fixtures and fittings.

There continues to be a range of single rooms (although these are not en-suite), and dormitory style bedroom areas. However, those that we spoke to found the mixture of accommodation helpful in supporting engagement with their peers.

The main lounge and dining areas have also been improved. They are multi-functional and offer ready access to food and/or drinks. There are additional facilities to support patient activities, with new games tables and areas for family visits.

Any other comments

We discussed our recent guidance on care planning with the SCN, and agreed that it may be helpful to develop a training session for staff at St John's on developing and documenting person-centred care plans.

Summary of recommendations

1. Managers should review the existing system for care files and develop a cohesive set of documents for the acute in patient ward that reflect person-centred care and that are routinely audited.
2. Managers should ensure authorised procedures under the Mental Health Act are followed appropriately.
3. Managers should ensure that the information about a patient's risks and time off ward is accurately reflected in their care file.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

ALISON THOMSON

Executive Director (Nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons Inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

Contact details:

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

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk