Mental Welfare Commission for Scotland

Report on announced visit to: Ward 1 (IPCU) , St John's Hospital, Livingston EH54 6PP

Date of visit: 18 February, 2020

Where we visited

Ward 1, the intensive psychiatric care unit (IPCU) in St John's Hospital, is a 12-bedded, mixed sex unit. It provides care for adults who are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 ('the Criminal Procedure Act').

The unit accepts admissions mainly from the West Lothian area, although there are admissions from other parts of NHS Lothian, as well as a service level agreement for access to two beds, for patients from NHS Borders.

We last visited on 21 February 2019, and made recommendations in relation to the input of pharmacy, care plans and specified person paperwork. On the day of this visit we wanted to follow up on action taken on the previous recommendations and also look at developments in the ward.

Who we met with

We met with and reviewed the care and treatment of six patients; there were no relatives/carers that wished to meet with us on the day of the visit.

We spoke with the senior charge nurse (SCN), the charge nurse and members of the nursing team. We also met with the general manager, the clinical nurse manager, the liaison psychiatrist, the clinical psychologist, the occupational therapist and advocacy.

Commission visitors

Moira Healy, Social Work Officer

Claire Lamza, Nursing Officer

What people told us and what we found

The patients that we spoke with on the day of the visit told us that they liked the staff in the ward and that they were helpful. We heard that for most, they found the input from staff supportive; they positively commented on different aspects of their care and treatment, such as the medication they were on, the activities that they were taking part in, and the contact they had with their doctor and nurses. We were told that during these interactions, they felt valued, listened to, were aware of their rights and involved in their care plans.

There were a few points raised by some. These related to some not agreeing with their mental health being an issue, while some were concerned with the risks posed by visitors to the unit, however we were told by those that we spoke to that they felt safe and well looked after. We discussed these issues with the staff on the day.

In meeting with all the members of the clinical team, we were advised that there have been a range of developments for the ward. We were pleased to hear that a previous recommendation on pharmacy input for the ward has been progressed and, it is anticipated that this post will be a new development for mental health services. We also were made aware that consideration is being given to aligning social work services to the in-patient mental health units. A few environmental developments are expected to take place in Ward 1 this year. Further work is expected to be undertaken in the courtyard garden area with Artlink and funding has been agreed for an enhanced care suite. This will support individuals who are in distress, and require more intensive input. We were informed that the suite will be an area where de-escalation can be done with greater privacy, where one-to-one sessions could take place, and where seclusion could be used, when required.

In addition to changes to the ward environment, we heard about team building and training that the majority of clinical staff have participated in. This has supported new approaches in psychological interventions, physiotherapy and occupational therapy. We were impressed with the sense of cohesion in the senior management group, and throughout the staff team for Ward 1. We also found that the training and subsequent interventions have added to the range of clinical interventions that staff are delivering for patients in the ward.

Care, treatment, support and participation

Ward 1 uses a combination of electronic records along with paper based care files. We found the files to be organised, easy to navigate, with up-to-date information. The day-to-day clinical notes are kept on the electronic system, however, it was also possible to see the patient's progress in the care file. We found detailed descriptions of staff engagement with the patient, and although these were not identified as one-to-one sessions, this was evident in the electronic record.

In all of the files that we reviewed, we found that the defined care goals gave a clear indication of the aspects of care that the patient and staff were working on. Given the challenge of engagement and participation with individuals who are in an IPCU because of their mental health needs, we were pleased to see that in some of the care plans, there was evidence of collaboration between the patient and staff. For some that we spoke to, they acknowledged that they were aware of what was in their care plan and we found care goals that were signed

off by the patient. We would encourage this level of collaboration and co-production with all patients in the unit.

We noted that while there was a standardised approach to the specific care goal associated with the management of preventing violence and aggression, other goals in some patients' care plans were individualised and person-centred. For some, there were comprehensive formulations that gave a detailed understanding of the individual's needs and clearly set out the treatment options and clinical management for the patient. We also found that the newly developed 'calm card', with the patient's top three strategies were incorporated into more recently developed care goals for some patients. We would hope to see this incorporated into all care goals at future visits.

There was evidence of reviews with the care plan documents and through the multi-disciplinary team (MDT) review sheet, although the level of detail and the standard of evaluation varied. For some, we found regular reviews of the care goals and comprehensive notes from the MDT review; in other there was a lack of detail. We also noted that the link between the care goals and what was reviewed at the MDT was not easily identified. We discussed this with the team and were advised that there is ongoing work in terms of the care plan template and auditing process for care files.

The Commission has produced good practice guidance on person-centred care plans which can be found at:

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

Recommendation 1:

Managers should continue to develop audit processes so that all care plan documentation is of the same standard.

Use of mental health and incapacity legislation

On the day of our visit, all patients in the unit were being treated under the Mental Health Act or Criminal Procedure Act. We found all of the relevant paperwork regarding the detentions in the care files and the electronic system. We found consent to treatment certificates (T2) or certificates authorising treatment (T3) were in place and that prescribed medication was authorised appropriately. We were advised that there was one T3 issue, but that this was being dealt with and the patient had been made aware of this.

For those patients in the ward who were under specified person's guidance, sections 281 to 286 of the Mental Health Act provides 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.

https://www.mwcscot.org.uk/node/512

We noted that for those patients who were specified, there was evidence of a reasoned opinion and the patient was aware of the restrictions and their right of appeal.

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

Rights and restrictions

There were no patients on increased levels of observation or individualised interventions on the day of our visit. In the near future, the unit will have an enhanced care suite; we discussed how this will impact on patients who are admitted and require this level of restriction. We heard that there are planned developments around the policy and practice that will be put in place once the suite is in situ.

In the care files that we reviewed, we found that risk assessments completed to a high standard. Where there were indications of recent events associated with identified risks, we found the assessment and review had been updated to reflect this. In some cases, the dates of assessments was not clear, and there were older assessments that were no longer applicable.

Recommendation 2:

Managers should ensure that the most current, dated risk assessment is kept in the care file.

On the day of our visit, we met with the advocacy worker, who was available to support the patients that wished to meet with us; those that we spoke to told us that they were aware of their rights. Where requested, patients had access advocacy or legal representation and this was recorded in the patients file.

As noted during our last visit, we did not find any evidence of advance statements in the care plans that we looked at. 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/rights-mind/

Activity and occupation

We were pleased to hear from nursing staff and the occupational therapist about the ongoing focus on activity and how best to engage patients in the IPCU. We discussed some of the difficulties that the patients have with motivation and concentration, as a result of their mental health, but noted that activities have been adapted to promote engagement. There has been further investment in equipment for physical exercise, and this continues to be a successful activity that the majority of patients participate in.

We heard about, and could see from the care files that a range of activities are available for patients. The regularly scheduled ones included arts and crafts, baking, mindfulness through colouring in, pool competitions, creative writing and quizzes. Activities are written up on a whiteboard at the entrance to the main day area, highlighting what is available each day. In

some care files, we found a record of what has been offered, and the outcome of this, but this was not in each patient's file; we would suggest that a record of activities is kept for all patients.

The physical environment

While we were pleased to see that the entrance to the ward is more visibly indicated, and on entering Ward 1, it appears spacious and well lit, it is soon noticeable that there are areas where the ward is in need of upgrade and refurbishment. We are aware that there is planned investment with the garden area and enhanced care suite, but in other parts of the ward, improvements are needed.

While we heard from patients that they appreciated having their own rooms with en-suite facilities, we noted that some patients have had to find ways of reducing the light from the corridor to better aide sleep at night due to the existing door fittings. There were also signs of wear and tear where fittings had been made to meet anti-ligature requirements, but are now in need of being upgraded.

There was also hazard tape on parts of the flooring and limited options for private interview spaces, particularly if there is a need for family visiting.

Recommendation 3:

Managers should develop a programme of work that addresses the updating and upgrading of the environmental issues for Ward 1.

Summary of recommendations

1. Managers should continue to develop audit processes so that all care plan documentation is of the same standard.

2. Managers should ensure that the most current, dated risk assessment is kept in the care file.

3. Managers should develop a programme of work that addresses the updating and upgrading of the environmental issues for Ward 1.

Service response to recommendations

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

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

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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