Mental Welfare Commission for Scotland

Report on announced visit to: Ward 17, Adult Acute Admission Ward, St John's Hospital, Livingston EH54 6PP

Date of visit: 21 February 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

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 10 December, 2019 and made recommendations about person-centred goals and auditing of care plans.

On the day of this visit we wanted to follow up on the previous recommendations and also hear what, if any effect from pandemic had had an impact on the patients and staff in Ward 17.

Who we met with

We reviewed the care and treatment of 11 patients; we spoke with four relatives and nine patients.

We also spoke with members of the nursing team and the senior charge nurse (SCN), one of the consultant psychiatrists for the ward, the clinical psychologist, the clinical nurse manager (CNM) and the service manager.

Commission visitors

Anne Buchanan, Nursing Officer
Claire Lamza, Senior Manager
Paula McCahon, ST6 Trainee
Graham Morgan, Engagement and Participation Officer (Lived Experience)

What people told us and what we found

The feedback we received from those that we spoke to covered a range of topics including their contact with staff, their experience of being on the ward, the activities that were available to them and views and opinions about the environment. We heard positive views expressed about the care and treatment from nursing staff, with those that we spoke to describing them as “brilliant” and “amazing”; we also heard that patients found the regular input from psychiatry, psychology and occupational therapy to be helpful and beneficial for their treatment and therapy.

We did hear that being on the ward can, at times, be difficult. We were told that the environment can be noisy, that sharing a dormitory with others can be difficult. We heard from some that they did not feel safe as they had witnessed some aggressive and hostile situations during their inpatient stay. We were also made aware that the activities on offer, while generally welcomed by most that we spoke with, did not always meet the needs of the different age groups, and that some found their anxiety increased when in group activities. We did hear positive comments about the food and drinks that were available.

The relatives we spoke with had a more mixed opinion about the care and treatment of their family member, however, there was a common theme about communication. While we heard from relatives that they found staff to be welcoming and helpful, they told us that often information about the plans for their relative’s care and treatment are not passed on to them, or that they do not feel included or heard in the discussions that take place about future plans.

We passed on these views to the SCN, CNM and service manager at the end of the visit.

Care, treatment, support and participation

We reviewed the electronic patient files where all relevant documentation and records are now all stored on TrakCare.

We found that the daily recording of progress notes provided a reasonable level of detail, and that there was a clear focus on the changes to the patient’s mental health. The progress notes also contained an account of the multidisciplinary team (MDT) reviews which noted who attended and outcomes of the meeting. These records also provided an update on changes with medication, the patient and carer views, where possible, the patient’s illness and symptoms and plans for treatment.

The patients’ care plans are also accessible via TrakCare and on the day of our visit, there was some variation in the styles of care plans that were being stored on the system. We discussed this with the SCN and the CNM and were advised that a different style of care plan is being trialled. We fed back that we found the newer version to be less adaptable to mental health care, and that the previous version was more relevant and usable for addressing mental health related goals. However, even these more mental health focused care plans varied in terms of the level of detail around specific interventions, the different clinical needs of the patient and the patient’s view and participation in the care planning process. We were pleased to see that the care plans and goals were regularly reviewed and when we asked about audit of care plans, we were advised that the peer audit approach is about to recommence. We would suggest that the previous care plan system provides better updates on care goals and that the use of

audit will help improve the overall consistency of documented interventions and with patient participation in care planning. We look forward to seeing these changes and improvements at our next visit.

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/node/1203

Use of mental health and incapacity legislation

TrakCare now holds the majority of documentation for those patients who were being treated or cared for under a legislative framework such the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') or the Adult Support and Protection (Scotland) Act, 2007 ('the ASP Act'). We found nearly all of the relevant paperwork for these Acts uploaded to the electronic system. We were aware some supporting documentation is forwarded by email, and depending on who the information was sent to, there were some issues in the uploading of this to the patient's records. We would suggest that an internal system for logging and adding key and accurate information relating to a patient's legal status is developed.

We reviewed and found that the consent to treatment certificates (T2) or certificates authorising treatment (T3) under the Mental Health Act were in place, and that the prescribed medication was authorised appropriately.

For those patients who were under the AWI Act, there were some difficulties accessing all of the key information on TrakCare. Where a guardianship order has been put in place, we would expect to find a copy of the application, or the granted powers, but these were not available on the system. We did find that where an individual lacked capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act that must be completed by a doctor, was available. This certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act. We noted that there was consultation with any appointed legal proxy decision maker and this was recorded on the form.

We also noted that where the use of measures under the ASP Act were indicated, accessing the key information raised at meetings was not available on TrakCare.

Recommendation 1:

Managers should ensure that any authorised procedures under a legislative framework are stored correctly and followed appropriately.

Rights and restrictions

We were pleased to see that the main entrance to Ward 17 remains open and has done so through the period of the pandemic. There was a discussion on the day about some of the challenges this presents, specifically when concerns have been raised about patients and visitors who breach some ward policies.

We recognise that having an open door may present different types of risks, especially for those who are inpatients. We did find that the documented risk assessments were person centred, comprehensive, detailed and reviewed regularly. We found that for those patients who were accepting their care voluntarily, they were aware of their rights to leave and return to the ward as they chose to; for those who were detained, and were able to have time off of the ward, there were visible and clear pass plans.

Those who we spoke with, and those whose care we reviewed were either aware of their right to advocacy, were accessing this service, and knew of their right to have legal representation.

When we were reviewing patient records, we looked for copies of advanced statements. The term 'advance statement' refers to written statements, made under sections 274 and 276 of the Mental Health Act, and is written when a person has capacity to make a decision on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements, however on the day of our visit, we were not able to locate any advanced statements. The Commission supports advance statements, as they are a way of ensuring that people with mental ill health are listened to and have their human rights respected. While we were pleased to note that there was an advance statement stored on TrakCare, would like to see evidence of the attempts made to engage with patients regarding advanced statements.

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

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

We were aware on the day of our visit that there were some circumstances where the use of specified persons would not be in keeping with our good practice guide. We discussed these with the SCN, who spoke to the RMO's involved, and a review of those patients who are specified under these restrictions are scheduled to be reviewed by the MDT.

Recommendation 2:

Managers should consider MDT training in the application and use of specified persons.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

Activity and occupation

We were pleased to hear that throughout the pandemic, access to activities and meaningful occupation had been maintained; we were also made aware that recently there has been additional input to the range of activities and occupation that is regularly available each and every day on the ward. Nearly everyone that we spoke to was positive about the different types

of activities, although we did hear from some that more tailored activities that suited their age or were available on a one-to-one basis would be helpful.

On the day of the visit, we could see groups taking place in the main lounge area; there was a visible activity planner on the ward, and we heard about some new opportunities where patients could access services, such as a social work drop in session, or low intensity psychological interventions, or recovery focused activities that are available.

Records on TrakCare gave a clear overview of each patient's activities, and there were also assessments undertaken by OT, with evidence of input from this discipline, the OT assistants and both activity coordinators, supplemented by one-to-one sessions with nursing staff.

We were also impressed with the development of psychological approaches that are available in the ward. At an MDT level, there are formulations that effectively help support and set out the options of engaging with patients, in addition to one-to-one input from psychology for those patients that are able to commence with this treatment option. We found the approach that the MDT in Ward 17 are taking to the care and treatment of those with emotionally unstable personality disorder (EUPD) to be forward thinking and supportive of national recommendations around the care and treatment of this group.

The physical environment

The environment has some challenges as a result of dormitory style rooms that are not en-suite, with only a few single rooms that have en-suite facilities. We heard that sharing a dormitory can impact on a patient's sleep pattern, can limit their privacy and for some, can leave them feeling unsafe. We were also made aware that there is no family visiting space available presently in the ward. While some patients advised us that they would prefer not to have their children visit, others told us that they if there was a dedicated area for this, it may be beneficial for them.

In some rooms, such as the interview area, we found there to be a starkness to the room, although the infection control requirements as a result of Covid-19 may have had an impact on the appearance of the area.

The main lounge and dining areas continue to provide spacious and well-lit areas that are multi-functional, with ready access to food and/or drinks. We were disappointed to hear that there has been no television in the main lounge for some weeks; patients told us that they had raised this, as did the SCN, but there has been no progress due to the need to have the TV placed securely. We also heard that access to WiFi was not always stable, so patients did not have an alternative when the television was not available.

Recommendation 3:

Managers should ensure the environment meets the needs of patients.

Summary of recommendations

1. Managers should ensure that any authorised procedures under a legislative framework are stored correctly and followed appropriately.

2. Managers should consider MDT training in the application and use of specified persons.

3. Managers should ensure the environment meets the needs of patients.

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

Suzanne McGuinness
Executive Director (Social Work)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

- We find out whether 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.

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