Mental Welfare Commission for Scotland

Report on announced visit to: Ward 3, St John's Hospital, Howden Road, Livingston EH54 6PP

Date of visit: 3 October 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 3 is a 12-bedded mental health acute admission unit for adults over the age of 65. The ward is located on the lower ground floor of St John's hospital. On the day of our visit there were two vacant beds.

We last visited this service on 26 February 2019 and made recommendations in relation to the remit of the ward and differing needs of the patients, nursing care plans, recording of one-to-one sessions with patients, consent to treatment under mental health and incapacity legislation and the environment. On the day of this visit we wanted to follow up on these recommendations and hear how patients and staff have managed throughout the current pandemic.

Who we met with

We met with one patient, and reviewed the care of, five patients. We met with one relative and received a letter from one other relative.

We spoke with the clinical nurse manager, the senior charge nurse (SCN), both charge nurses and two consultant psychiatrists.

Commission visitors

Gillian Gibson, nursing officer

Lesley Paterson, senior manager, east team (practitioners)

Alyson Paterson, social work officer

What people told us and what we found

Care, treatment, support and participation

The feedback we received was generally positive. Nursing staff were praised by the patient, relatives and psychiatrists. We heard they were “respectful”, “excellent”, and “caring” and go “above and beyond” in their roles. They were described as “team players” who take a holistic approach to both patient and relatives’ needs.

On our last visit, we made a recommendation that one-to-one sessions with patients are recorded to evidence both participation and nursing input. On this visit we saw evidence of detailed one-to-ones in the patient records, but heard that more frequent one-to-one sessions would be helpful.

We found the ‘Getting to know me’ booklet was used for some patients, mainly those with a cognitive impairment. Although we recognise that this booklet was designed to support hospital staff to gain a better understanding of patients admitted to hospital with a diagnosis of dementia, we heard from relatives that they felt they could be more involved in specific information sharing, particularly in regard to sharing of background information. We suggested that the ‘Getting to know me’ booklet could be a useful tool to gain a better understanding and insight into all patients in the ward, particularly about what is important to them.

On our last visit we were told by senior managers that an improvement plan was in place for Ward 3, which included reviewing the mix of patients. We had made the recommendation that managers should review the remit of the ward to consider the differing needs of patients. We were disappointed to learn that this work has not progressed and we heard about the ongoing challenges for staff and patients with having an acute admission ward which admits patients who have a functional mental illness and also patient with a diagnosis of dementia.

Recommendation 1:
Managers should review the remit and function of the ward to ensure the differing needs of the patient group are met.

Care planning

When we last visited the service we recommended care plans should be audited to ensure that they are person-centred and gave a description of the interventions required. We also recommended, where possible, that participation should be evidenced.

On this visit we found a range of care plans covering the physical needs of the patients but it was recognised that the electronic system used was not designed for use in mental health services. We heard from staff the difficulties they have creating person-centred care plans for mental health and wellbeing on this system. We discussed with staff on the day the importance of having detailed, person-centred care plans that addresses the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. These should be descriptive of the interventions required to provide individualised care, particularly in relation to mental health.

There appeared to be a lack of discharge care planning which we would expect to find in an assessment ward. We heard that patients and relatives were unclear as to what goals had been identified to support discharge back into the community.

Although we were able to see that care plans were being reviewed, the electronic system does not support a full review of effectiveness of interventions. We were unable to locate robust summative reviews that targeted nursing interventions and individuals' progress to meet specific goals and interventions.

We were unable to find evidence of patient and/or relative participation and we heard that patients and relatives did not feel involved in care planning; we heard that patients had not received copies of their care plans. We would also have hoped to see patient views on their care plans captured using their own words.

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

Recommendation 2:
Managers should review the electronic system currently in use and its ability to support care planning for mental health and wellbeing. Managers should ensure there is an alternative means to capture individualised person-centred care planning in the meantime.

Recommendation 3:
Managers should ensure care plan reviews are meaningful, and include the effectiveness of interventions and reflect any changes in the individuals care needs.

Recommendation 4:
Managers should ensure all patients are supported to be fully involved in creating person-centred care plans, that they receive a copy of them and patient participation is recorded. If a patient chooses not to participate, then this should also be recorded.

Recommendation 5:
Managers should ensure all patients and/or relatives are supported to be fully involved in creating person-centred, recovery focused discharge care plans with clearly identified goals.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) of nursing, psychiatry and occupational therapy (OT) staff who are either based in the unit or who are accessible to patients. There is pharmacy input to MDT meetings and support from medicine of the elderly (MoE) for physical healthcare. Referrals can be made to all other services such as dietetics, physiotherapy and speech and language, as and when required.

MDT meetings take place weekly and it was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and provide an update on their views, including community and social work staff. MDT meetings are well documented with outcomes and actions from each meeting. There is an open invitation for relatives and carers to attend if they wish but we found limited evidence patient

involvement. We heard that at times it is not deemed to be in a patient's best interest to attend, particularly if they are acutely unwell; staff would provide an update to the patient following the meeting. We would expect to find evidence of a reasoned discussion recorded in the patient's notes if it is deemed the patient is unable to attend.

Physical healthcare of the patient group is supported by an MOE consultant. We also saw evidence of input and support from a range of professional including dietetics and physiotherapists.

We heard that there have been ongoing difficulties in the recruitment of a psychologist for the ward. We had been concerned to hear that previously, psychology had only provided input to patients with a cognitive impairment and were pleased to hear the current post advertised is to support the care and treatment of all patients in the ward.

We were also concerned to hear about a vacant consultant psychiatrist post and the impact this was having on the other psychiatrists in the ward. We heard this post had been vacant for three months and the matter had been raised with hospital managers. Concerns were raised about the standard of care patients were receiving when there was no identified responsible medical officer (RMO), particularly for patients detained in hospital under the Mental Health (Care and Treatment) (Scotland) Act 2003, (MHA). Hospital managers have a legal responsibility to allocate an RMO for every patient detained under the MHA.

Recommendation 6:
Hospital managers should ensure appropriate provisions are in place for all patients to have an identified allocated RMO/psychiatrist on admission to hospital.

Care records

The ward uses the electronic system Trakcare to hold, and record information on patient's care and treatment. We found this system relatively easy to navigate although recognised this system was not designed for mental health services. We were able to find specific information located on the system. We found that overall, there was a good standard of record keeping with daily notes linked to care plans.

Some information was also held in paper format. We found these records disorganised with a lot of information that was incomplete or out-of-date. Some information was duplicated from the electronic system. We found the wrong information recorded for one patient regarding Mental Health Act detention dates and information filed in the wrong patient's folder.

Recommendation 7:
Managers should ensure a review and audit of all patient records is undertaken to ensure information held is in the appropriate place, is factual and in good order.

Use of mental health and incapacity legislation

On the day of our visit, four patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Documentation pertaining to the Mental Health Act was accessible and in order. On our previous visit we made a recommendation in relation to compliance with part 16 of the act. Part 16 sets out the

conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. The forms authorising treatment (T3) were available but we were concerned to find two patient's had been prescribed medication not covered by the T3. We raised this with managers on the day of our visit.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found details of this in the patient's file. However, one of the relatives we spoke to was unaware of their rights as a named person. We raised this with managers on the day of our visit.

Where an individual lacks capacity in relation to decisions about medical treatment, a section 47 certificate of the Adults with Incapacity (Scotland) Act 2000 (AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that the treatment complies with the principles of the AWI Act. We previously made a recommendation regarding s47 certificates and were pleased to find consent to treatment certificates were in order and accompanied by detailed care and treatment plans.

There appeared to be a level of uncertainty whether there were welfare proxy (guardianship or power of attorney) in place and there did not appear to be a clear process to identify this. This is necessary to ensure details are recorded and copies of powers are kept in individual files. Staff we spoke to were unsure of what powers were in place. We discussed the importance of knowing what powers had been granted to the welfare proxy and what powers had been delegated to them as care providers. Uncertainty regarding legal powers in place can lead to decisions being made without proxy involvement.

For those patients on covert medication pathways, all documentation was in place and reviewed regularly, however a number of these did not evidence relative/carer/proxy involvement which we would expect to see.

Recommendation 8:
Managers should ensure that all certificates authorising treatment under mental health legislation are in place where required and legally authorise the prescribed treatment.

Recommendation 9:
Managers should ensure that training and education is available to staff to promote and enhance their knowledge and understanding of the Adults with Incapacity (Scotland) Act 2000.

Recommendation 10:
Managers should ensure that where there is a welfare proxy in place, a copy of the certificate is obtained for ward records and evidence of discussion with the proxy about how any powers are delegated to staff is clearly recorded.

Rights and restrictions

Ward 3 continues to operate a locked door policy, commensurate with the level of risk identified with this patient group. This policy was available on the ward with an easy read version displayed for patients.

We found detailed risk assessments in place for each patient that identified strengths and protective factors. These were reviewed and updated regularly.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Act, and where restrictions are introduced, it is important that the principle of least restriction is applied.

On the day of our visit, where there patients subject to specified person legislation, however we were unable to locate copies of reasoned opinions. The RMO must record a reasoned opinion setting out why without the particular restrictions being in place, there would be a risk to the individual or to others. This action, together with notification to the patient, the patient's named person and the Mental Welfare Commission legally constitutes the designation of a patient as a specified person.

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

Recommendation 11:
Managers should ensure where specified person restrictions are in place, the appropriate documentation, including a reasoned opinion is completed and available in patient files.

When we are reviewing patient files we look 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 decisions on the treatments they want or do not want should they become unwell again in the future. Health boards have a responsibility for promoting advance statements. On the day of our visit we saw a Mental Health Act form detailing whether there was an advanced statement in place, however, we were unable to locate evidence in the care records and care plans that discussions were taking place in relation to advance statements. Patients and relatives were not aware of what these were, or their right to make one. The Commission supports the use of advance statements, as they are a way of ensuring that people with mental ill health are listened to and have their human rights respected. We would like to see evidence of the attempts that are made to promote and engage patients in a discussion regarding advanced statements, and the reason noted for any patient who does not have one.

We were pleased to hear that advocacy services had resumed face-to-face visits and heard that patients are referred for advocacy support.

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

Activities are currently provided by an activity coordinator and OT staff. There is an activity programme in place which details activities scheduled for the week including arts and crafts, baking and games. We were pleased to see music therapy being offered on a weekly basis.

We saw detailed entries in patient notes of activities offered and undertaken and in addition to the ward planner, each patient is has an individualised activity care plan that identifies interventions and opportunities to promote engagement in activities.

However, we heard that activities on offer were not always of interest to patients in the ward. We spoke with managers on the day of our visit and again suggested the use of the 'Getting to know me' booklet for all patients, which would assist in identifying specific likes, dislikes, hobbies and interests.

There is a kitchen area in the ward that patients can use for laundry and baking groups and we saw evidence of kitchen assessments undertaken by OTs.

The physical environment

The layout of the ward consists of six single rooms with toilet facilities and two bays which could be used for three or four patients at a time. There is a quiet room, and an open plan sitting and dining area. The ward also has access to a courtyard garden.

We saw that efforts had been made to soften the quiet room to make this more therapeutic for use, however we found the rest of the ward to be stark, clinical and uninviting. This has been commented on in our last two visit reports.

We also found the ward disorientating with very little signage which can cause confusion for the patient group, particularly those with dementia. There was no evidence of personalisation of bed space areas, particularly in the bays. We heard the difficulties patients experience in the bays, particularly with noise and lighting.

There are toilets and shower rooms in the bay areas and a further shower and bathroom in the main ward. These were also stark and clinical in appearance and in need of updating.

When we last visited, we recommended a review of the current environment to consider how it may be both more welcoming for patients and how the space might be reassigned to meet the needs of the patient mix. We were disappointed to learn this had not been undertaken.

Recommendation 12:
Managers should ensure that if the ward is to provide an environment for individuals with a diagnosis of dementia, then an assessment should be undertaken and the findings from this implemented.

Recommendation 13:
Managers should ensure that the ward environment is welcoming and fit for purpose with efforts made to personalise bed spaces and rooms.

Any other comments

We heard from staff about the confusion surrounding patients on delayed discharge. We were told the clinical team determine when a patient is medically fit for discharge and this is indicated to the delayed discharge hub who meet daily via Trakcare. Staff have found patients have been removed from the delayed discharge list with uncertainty around the reason for this and lack of communication with ward team. We were concerned that if patients were being

removed from the list then being added, this may not give an accurate reflection of those figures. We discussed this on the day of our visit with managers and learned the discharge hub was planning to offer training to ward staff to aid understanding. We also suggested more open lines of communication between discharge hub representatives and ward staff.

We were concerned to hear of practices in the ward in relation to patient finances. We heard when patients were deemed to be too unwell to access their bank, a hospital bank account is opened for them. However, we were told that acutely unwell patients can be assisted to transfer money from their own bank account to their hospital account so that essential items can be purchased for them. One patient we spoke to was unclear about why money was transferred and told us that he had given staff a financial gift. This practice leaves both patients and staff vulnerable, as an acutely unwell patient may not have capacity to make such a decision.

We were concerned that patients did not fully understand what this money was being transferred for and how it would be used.

Recommendation 14:
Managers should ensure there is a ward policy in place for the management of patients' funds and any decisions regarding an individual's capacity to consent to monies being transferred is legally authorised and fully assessed by the MDT with all discussions and decisions documented.

Summary of recommendations

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Managers should review the remit and function of the ward to ensure the differing needs of the patient group are met.

Recommendation 2:
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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.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

- We find out whether 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

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk

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