Mental Welfare Commission for Scotland

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

Date of visit: 15 June 2023

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 21 February 2022 and made recommendations in relation to storage and application of Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) legislation, this included individual staff understanding of sections 281 to 286 of the Mental Health Act. We also made a recommendation about the environment; we were concerned there were some areas of this admission ward that required 'softening' as they were stark. Furthermore, we were told there was no dedicated space for families with children to visit. On this visit, we were pleased to see the new family room, which now provides a dedicated safe and welcoming space for families to visit the ward, with a selection of toys for younger visitors.

This visit to Ward 17 was an unannounced visit, and whilst we would always hope to meet with family members during our visits, this was not possible on the day. We asked for our contact details to be shared with relatives, should they wish to speak with us to discuss their family member's care and treatment.

Who we met with

We met with 11 patients in person and had the opportunity to review their care records.

We had the opportunity to meet with several staff from the multidisciplinary team, including the senior charge nurse, charge nurse, clinical nurse manager, general manager, consultant psychiatrists and psychologist.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

Dr Neha Bansal, ST6 trainee

What people told us and what we found

Care, treatment, support and participation

During our meetings with individual patients, we discussed a range of topics that included contact with staff, patients' participation in their care and treatment, activities available to them, and views about the environment. We were also keen to hear from patients who would usually have been admitted to the Royal Edinburgh Hospital, however, due to inpatient bed capacity issues in Edinburgh, it had been necessary to admit them to St John's Hospital in Livingston instead.

We were told by patients that staff were "lovely", "eager to help" and "approachable". We also heard that staff responded quickly when patients were distressed and required support. For some patients there was a sense that whilst activities were available, not all patients were keen to engage. Some told us they would have preferred alternative opportunities for recreational and therapeutic engagement, particularly in the evenings or over the weekend. Patients told us they found the environment therapeutic, welcomed the new family room and found it to be a relaxing space. On the day of our visit, the ward was exceptionally warm, with no ability to open windows and without air conditioning. Patients reported that they found the ward's temperature difficult to cope with at times. We are aware there had been some remedial work carried out to the windows on the south facing aspect of the ward, however, due to health and safety concerns the windows could not be opened to allow fresh air into the ward.

On the day of this visit there were nine patients in Ward 17 that were there due to ongoing bed capacity issues in the Royal Edinburgh Hospital. We heard from staff that it was important that every patient was provided with consistent, compassionate care and treatment, however, we also heard from some staff that on occasion, they experienced difficulties with communication between themselves and mental health teams in Edinburgh and the Lothians. This sense of providing treatment for patients without having regular input from the patient's usual care providers was challenging for some senior staff. There was a recognition that communicating with a significant number of inpatient services in Edinburgh and the Lothians, community mental health teams and responsible medical officers created more complexity and challenges. However, we were advised that there were regular meetings with key staff and managers from each locality, in order to ensure continuing communication and discharge arrangements were agreed, before patients were discharged from Ward 17 back to Edinburgh and Lothian mental health services.

We heard from patients that their admission to St John's Hospital felt far from ideal for several reasons. We heard that not all patients' relatives were able to travel from Edinburgh, East or Mid Lothian, which had an impact on patients' continuing contact with family members. Arranging passes to visit a patient's home was another issue, due to geography and the need to have the staffing resources to undertake escorted visits, which was a challenge. Patients told us that at times, they had felt isolated and while staff were making every effort to ensure their admission to hospital was comfortable, patients would have preferred to be in their local hospital. We recognised that for some patients, discharge from inpatient care could, at times, be a difficult transition. The clinical team has a responsibility to ensure all discharge planning arrangements are agreed between services; patients should have details of those

arrangements and who will be providing post discharge support. This should extend to informing relatives of the discharge arrangements, providing them with contact details of the support provider and who should be contacted should their relative require support out of hours.

Care records

Of the patients we met with, we also reviewed their electronic care files; all documentation was stored on TrakCare. We found the electronic records easy to navigate and were pleased to find all paperwork relating to the Mental Health Act was stored securely on this electronic system. We found the daily recording of progress notes to be detailed, and 'canned text' (pre-written text) was used to support staff to ensure the key areas in a patient's presentation were accounted for. We would like to have seen a subjective view from patients, and a narrative to consider how a patient was on a day-to-day basis. We were aware there was information gathered from each discipline and patients before the weekly MDT meeting, nevertheless, having a daily opinion from a patient would have been beneficial.

Some patients described feeling involved in their care and treatment; their expectations for their admission to hospital were clearly communicated to staff and an account recorded in their care records. However, other patients were unable to describe, for example, details of their care plan. They were not aware of specific goals, interventions or whether their care plans had been reviewed regularly and by whom. We reviewed several care plans held in the electronic care records and found those not to be person-centred. We could not find evidence of patient participation and there was a lack of detail specifically in relation to an individual's risk, needs and goals for their admission to hospital. We had difficulty finding care plans that were reviewed and updated as necessary and there seemed to be a limitation to the extent of how care plans could assist with a patient's recovery.

The senior leadership team told us that a new format for care planning would soon be introduced to improve the functions of specific areas of care that had been identified as necessary. This new format would invite a greater opportunity for staff and patients to work collaboratively to ensure each care plan was bespoke and person-centred. The new format will allow the patient to have their own paper copy of their care plan that was not currently available to them. We suggested an audit of existing care plans may be beneficial to determine the current quality, highlighting specific areas in which improvement is required, to ensure the new format is successful.

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 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Multidisciplinary team (MDT)

Ward 17 had a broad range of staff providing input for each patient. There were nursing staff, consultant psychiatrists, occupational therapists, a psychologist, an art therapist and activity co-ordinators. For patients who required additional support from allied health professionals, referrals were made to specific services. Each member of the MDT provided care and treatment specific to their expertise and provided weekly feedback at the clinical team meeting, outlining each patient's progress. Nursing staff told us they had received additional training to enhance their nursing skills. This included a more psychological approach to working with patients who had experienced trauma. Patients had input from psychology, where there is an emphasis on psychological formulations; these were helpful for the patients and staff as they provided an understanding of a patient's presentation and behaviours. We were told that whilst patients did have opportunities to engage with psychology, the ward would benefit significantly from additional psychology resource, as the psychologist had commitments across other inpatient services. We heard that all staff had opportunities to engage with reflective practice sessions which were facilitated by psychology and there was a commitment to ensure staff were supported in their roles in the ward.

The ward-based MDT staff had adopted a consistent multidisciplinary team model of care and treatment. In the team, each staff member had responsibility to provide care aligned to their expertise. We saw detailed functional assessments undertaken by the ward occupational therapists. Psychology provided psychological and risk formulations that ensured there was a whole team approach to understanding patient experiences. The MDT appreciated patients who had been in the ward for a prolonged period could require additional support to assist with transition from hospital back into their community. There was an emphasis on supporting patients with this transition, which included a period of outreach with ward-based activity co-ordinators taking on specific roles to include community-based activities.

Use of mental health and incapacity legislation

On the day of our visit several patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Of those patients subject to compulsory treatment under the Mental Health Act, we reviewed the legal documentation available in the electronic records.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were mostly in place. We identified two issues and spoke with medical staff on the day of the visit to ensure errors were rectified.

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 copies of this in the patient's file.

Rights and restrictions

We were pleased to see the main entrance to Ward 17 remained open, with the door only being locked when necessary and overnight. We recognised having an open door can bring about some challenges, however, we were pleased to see patients who were subject to the Mental

Health Act and specific restrictions had detailed pass plans to ensure they had opportunities to have time off the ward. We were concerned to hear that for some patients who were not subject to Mental Health Act legislation and were accepting their care voluntarily, they were uncertain whether they were in hospital voluntarily or formally.

Recommendation 2:
Managers should ensure patients are informed of their detention status and that information is provided to all patients to ensure they are fully aware of their legal status and their rights.

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 this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place. We were pleased to find staff were knowledgeable about specified person legislation, and storage of paperwork relating to this legislation was easy located in care records.

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 were pleased to hear there were two activities co-ordinators who were supernumerary to the ward's nursing establishment. We heard that this ensured their time was dedicated to organising ward-based and community activities. This also extended to a gardening project that patients could continue to attend following their discharge from the ward.

Patients told us they enjoyed participating in the activities provided by staff, however, some felt they would also have liked opportunities for recreational engagement in the evenings and for this to be extended to weekends too. Patients were also supported to engage with therapeutic activities provided by art therapy, occupational therapy, and other allied health professionals, such as dietician and physiotherapy. For patients who were working towards discharge from hospital-based care there was an emphasis to support this transition to enable a successful and sustainable discharge from hospital. Activities co-ordinators supported patients to build confidence with shopping, travelling and social contacts.

The physical environment

The environment had some challenges due to dormitory style rooms that were not en-suite, with only a few single rooms that had en-suite facilities. Patients told us they would like to have been given a choice whether they had a single room or shared a dormitory with other patients. We heard that sharing a dormitory could impact on a patient's sleep pattern, limit their privacy and for some, could leave them feeling unsafe. We also heard that for some patients, witnessing behaviours of patients who were very distressed, or hostile had been difficult to cope with. We discussed this with the leadership team on the day of the visit to remind them that for some patients who have been adversely affected by childhood or adult trauma, sharing a space can evoke feelings of stress and tension.

We were pleased to see there had been an investment in the environment with a new dedicated family room, new modern dining room furniture, murals, and colour to the walls in the communal areas. During our last visit to Ward 17 patients told us they did not have access to a television, so we were pleased to see there were now two in-situ. Unfortunately, access to Wi-Fi was not available due to current coverage. This was a source of frustration for patients and for staff, as the latter were limited in how they could assist with this issue.

The ward was bright, clean and well maintained. We wish to acknowledge the ongoing input and commitment from domestic staff to ensure Ward 17 remains a welcoming environment.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Recommendation 2:
Managers should ensure patients are informed of their detention status and that information is provided to all patients to ensure they are fully aware of their legal status and their rights.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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