Mental Welfare Commission for Scotland

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

Date of visit: 12 December 2023

Where we visited

Ward 3 is a 12-bedded unit divided into two gender specific dormitories and six single rooms. The unit provides assessment and treatment for older adults who experience functional or organic mental illness. On the day of our visit, it was over capacity with 14 individuals admitted to the ward, of which one was out on pass.

Six of the individuals were categorised as delayed discharges, meaning that they were regarded to be clinically fit for hospital discharge but could not leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available.

We last visited this service in October 2022 and recommended that managers should review the remit and function of the ward to ensure the differing needs of the patient group were met.

On the day of this visit we wanted to follow up on the previous recommendations and look at how the ward was functioning. We were aware that there had been a significant change in the nursing team since our last visit and as before, we wanted to find out if there had been progress where recommendations had been made.

Who we met with

We met and reviewed the care of six individuals. We spoke with the general manager, the occupational therapy assistant, the senior charge nurse, other members of the nursing team, and the service manager for the acute service who deputised for the service manager that usually covers Ward 3.

Our visit coincided with the Christmas Fayre event, so we were able to observe interactions between the staff, individuals and their families and we were pleased to see that these were warm and caring exchanges and there was a pleasant ambience on the ward. One family member commented about how “fantastic” the whole event had been for their mother including the preparations and was complimentary about staff.

Commission visitors

Denise McLellan, nursing officer

Kathleen Liddell, social work officer

Gillian Gibson, nursing officer

What people told us and what we found

Care, treatment, support and participation

All individuals described the care that they received as good, and told us that nursing staff were helpful. One commented that staff were "excellent" and that if they needed help with anything, this was always provided. Generally, the food was described as good however, some felt the portions were insufficient. Some commented that they found the ward very noisy at times with doors banging when they closed over, which was unsettling. It was also noted that some were unhappy sharing a dormitory due to the lack of single rooms and they said this could be disruptive and noisy owing to other individuals' presentations and care needs.

Another issue reported to us from most of those that we spoke with was that they found activities on the ward to be limited, and they would like to have had more to do, as they spent lengthy periods lying on top of their bed and felt bored. For those that were admitted on a voluntary basis, there was a lack of awareness of their legal rights. We also found that many were unaware of the reason for their admission, and future planning, including their discharge from hospital. Some were aware that they had a named nurse however, nobody was able to say who that was.

Care planning

Following our last visit, we recommended that managers ensured that there was individual or family participation in the creation of person-centred care plans and that individuals should receive a copy. We were disappointed to find no evidence of improvement in the documentation, and found them to be prescriptive, generic and did not provide details of how goals would be achieved.

We noted that there was a range of care plans covering physical health, however the care plans relating to mental health and general wellbeing were sparse in detail. One care plan listed a goal as "to get better and go home relatively quickly" with no detail or individualised intervention on how this could be achieved. Care plans should be individualised, and person-centred, describing interventions in detail. These should be done in conjunction with ongoing evaluation to measure their effectiveness in achieving specific goals.

Although we found numerous care plans available, we found them to be generic, with no evidence of reviews or progress made. One recorded that an individual had not wished to participate in writing the care plan, however no information was provided on how they could be supported to participate. We were unable to find any links to the care goals in the care records or individuals' views about the care plans being developed in the person's own words.

We were told that the care plans were reviewed monthly on the TrakCare system, however we were unable to locate any reviews. We asked nursing staff to assist but they were also unable to locate them on this system. Staff had previously commented that the system did not lend itself to creating person-centred care plans for mental health and wellbeing, however we shared information about care plans that were of a high standard written in other areas using TrakCare in NHS Lothian. We suggested that it may be helpful to link in with these areas.

We were told that care plans and reviews were being looked at by the service as a whole and suggested using the Commission guidance on our website to help in the process. We

recommend that an audit of the care plan reviews is carried out to ensure that they reflect the work being done with individuals towards their care goals and that the reviews are consistent across all care plans.

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 must ensure nursing care plans are person-centred, contain individualised information reflecting the care needs of each person, identify clear interventions and care goals**,** include a summative evaluation indicating the effectiveness the interventions being carried out and any changes required to meet care goals.

Recommendation 2:
Managers must ensure individuals'/family/carers' participation in care planning is evidenced in the care file.

Recommendation 3:
Managers should carry out an audit of the nursing care plans to ensure their quality and that reviews are meaningful and fully reflect the individual's progress towards stated care goals and that recording of reviews are consistent across all care plans.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines involved in the weekly MDT meetings and it was clear from the very detailed records that everyone involved in an individual's care and treatment was invited to attend and provide an update on their views. Documentation evidenced input from nursing, social work, pharmacy, occupational therapy (OT) and psychiatry. We were told that the service was in the process of acquiring psychology provision that will be provided from an inpatient perspective to Ward 3 at St John's. This service will have a remit to provide assessment and training around the 'Newcastle Model of Care' for stress and distress behaviours, in addition to individual psychological therapies for individuals with functional illness.

Other referrals could be made to disciplines such as dietetics, physiotherapy, or speech and language therapy where required.

There had been significant personnel changes during the past year, including the managerial team. One deputy charge nurse (DCN) had been appointed on the day prior to our visit and the senior charge nurse (SCN) had not been long in post. There had been recent interviews for vacancies including two staff nurses, two healthcare support workers and there were vacancies for an OT and an OT assistant. We were pleased to hear that gaps in the consultant psychiatry provision had been addressed and there were five consultant psychiatrists, some of whom worked on a part-time basis. There had also been improvements made to how individuals were allocated their responsible medical officer (RMO). We saw a copy of the allocation system displayed on a board in the nursing office, making designation by geographical area easy to identify.

We were able to find clear discharge planning information in the MDT meeting notes and this has been complemented by the attendance of social work. This full MDT inclusion was beneficial in terms of discharge planning and noted that community psychiatric nurses (CPNs) also attended when required. The MDT template was robust and had improved the quality of the meeting, making it more structured; there was clear recording of meeting attendees. Individuals were not invited to these meetings and we were told that this was due to time constraints, but their views were sought for discussion prior to the meeting. However, we were unable to see any evidence of discussion, feedback or views around care and treatment sought from individuals following the meeting. We also felt that there needed to be further discussion in relation to individuals' rights.

In one of the records that we reviewed, we saw that an individual's capacity had been discussed with an outcome of them being deemed capable of making their own welfare decisions, and a full discussion taking place about their care plan and specific treatment, including arranging a family meeting.

We noted that these family meetings were attended by social work, nursing and psychiatry along with the individual and their families. The records evidenced that these meetings occurred regularly and provided an opportunity for views and concerns to be heard and for diagnosis and medication to be discussed clearly. A plan for discharge was also considered and what was required to achieve it.

Care records

Information on individuals' care and treatment was held on the electronic record system, TrakCare, which although not designed for mental health services, it was relatively easy to navigate. We found these records to be of a mixed quality, with some providing information on how individuals had occupied their day and interactions with others, whereas others gave minimal information, mainly referring to care tasks and receiving medication. Continuous use of phrases such as "low profile" and "evident on the ward" gave no detail on how this person occupied their day, or about their thoughts, feelings or any concerns they may have had. We suggest that the use of canned text would be helpful to prompt staff to provide more comprehensive entries. We saw it was used in some continuation notes, but not consistently or extensively. An example of this was in relation to 'as required' medication administration where it recorded that it was "given as per prescription", with no information about response, concordance, or possible side effects.

There was evidence of consultant psychiatry reviews which detailed discussion with families about plans for passes home, medication reviews, and any referrals required, for example to audiology and physiotherapy. Pharmacy input was also evident from the notes. Regular, thorough and detailed medical reviews were noted to be taking place outwith the MDT meetings. Minimal entries were found of one-to-one interventions with nursing staff, however when documented, they were of a good quality. The OT entries were detailed, with assessments being followed up. We found an example of telephone contact with one family when seeking information about the person's functioning for a functional assessment; it was both detailed and collaborative. Ward 3 was still using the 'Getting to Know Me' booklet which provided helpful information about each individual, but not all booklets had been completed.

Risk assessments were available in the electronic records, but we noted that these were historical, written by other services, then updated on admission to the ward. As a result, we had to scroll to the bottom of the risk management plan to find the most current information. We felt that this could create risks, as those risks that were evident in the community could be very different to those in hospital. One had been completed in the community in December 2022 and although we saw evidence of reviews, the information was not pertinent, as it referred to treatment and not risk. Another review commented on an individual being "pleasant and polite during interactions and bright on the surface".

We felt that new risk assessments should be completed at the time of, and during the early stages of admission, as there would likely have been some deterioration in presentation to require admission, therefore the risks could have changed. In one case, we read that an individual had a risk of aggression towards others but was now in a ward with other vulnerable people and staff; there was with no risk management or safety plan in place for this.

Recommendation 4:
Managers should ensure risk is assessed and evaluated on admission to the ward to include any changes in the risk profile, triggers and how it will be managed.

Use of mental health and incapacity legislation

On the day of our visit, three of the 14 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Although none of those who were detained wished to speak with us, we were able to locate their Mental Health Act documents in the records. The other individuals we did speak with did not appear to have a good understanding of their status and did not know that as they were admitted to the ward on an informal basis, and they could choose to leave. We highlighted that more discussion was needed around this. Positively, we found evidence of advocacy involvement when reviewing the care records.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. There was no requirement for consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act due to the recentness of admission to hospital for two individuals and a designated medical practitioner second opinion request had been made for the other individual who had been on the ward slightly longer.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate under section 47 of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found s47 certificates on file however, one had no treatment plan attached.

We were pleased to see discussion in the notes regarding a welfare guardianship order application (WGO) and where someone had been assessed as not being able to instruct a solicitor, a curator ad litem had been appointed to safeguard their interests in the Mental

Health Tribunal proceedings. We also found a copy of a power of attorney certificate (POA) scanned and uploaded to TrakCare.

The whiteboard in the office indicated 'AWI' for some individuals but did not specify whether this related to a s47 certificate, POA, WGO or financial guardianship under the AWI Act. Staff need to be clear which part of the act is applicable so that if there are proxy powers, they can have discussion with the proxy to be informed on decisions about care.

The SCN informed us that training had been undertaken, however due to awareness of ongoing issues, further training had been booked for January 2024. This training will deliver education to the nursing staff specifically about the AWI Act legislation and authority to discharge and will be provided by a mental health officer (MHO). We reminded staff that there was also AWI Act training available on the TURAS platform.

Rights and restrictions

Ward 3 continued to operate a locked door, commensurate with the level of risk identified. On our last visit the policy had been available, with an easy read version displayed for individuals. We did not see this and raised this with the SCN who thought it may have been temporarily removed to decorate ward for Christmas and we were reassured this would be rectified. Individuals who had been admitted informally were not clear on their right to leave the ward and told us "the rules were the same for everyone".

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 an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. None of the individuals were subject to these measures on the day of our visit and there were no individuals on an enhanced level of observation or nursed in seclusion.

The term 'advance statement' refers to written statements made under ss274 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. Health boards have a responsibility for promoting advance statements. We were unable to find any in the records we reviewed or any recorded discussion with individuals about these. We did not observe any posters or leaflets promoting advance statements in the ward.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals 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

Recommendation 5:
Managers should ensure staff are knowledgeable about advance statements and these are promoted, completed, and recorded for individuals well enough to choose to complete one.

Activity and occupation

Feedback about the level of activity offered was mixed. One person said they spent all day in bed as there was nothing to do, whereas another said that there was enough to do if you chose

to, including cooking and laundry with the OT to increase their skills for future discharge. We saw that Tai chi had been offered to one individual by OT in addition to Christmas decoration making with the activity co-ordinator. However, we found no further evidence of engagement in activity, as nothing had been documented to say whether participation had been offered and declined. Another person told us that they had been in the ward for five days with no activities offered in that time. We were told by another individual that they were being taken to a local football match at the weekend, which they were pleased about.

We found a list of activities that had been compiled by the activities co-ordinator in a folder in the activity room. Information was provided about how it supported and benefitted individuals, such as helping to promote conversation, social inclusion, reducing anxiety, skill development, communication and promoting confidence. Activities included: arts and crafts; air hockey; baking; breakfast group; café outing; gardening group; mindful colouring; reminiscence group; newspaper group; pool; quiz; walking group; dominoes; indoor bowling and darts. We were also informed that individuals were invited to a weekly ward community meeting to discuss issues such as new activities they wished to pursue. Despite this extensive list, the records did not reflect this level of activity on offer or any significant level of engagement. We would like to see the inclusion of tailored therapeutic activity care plans and how these link to treatment, as most individuals we spoke with reported boredom and one person complained that they were "bored to tears".

The charge nurse told us about the meaningful activity centre (MAC) for individuals experiencing stress and distress which was located on the ground floor in the same block. She had already referred someone to this resource and added that referrals could be made for others who may benefit.

Recommendation 6:
Managers should ensure activity care plans are person centred, reflecting the individual's preferences (alongside activities specific to their care needs) and that all activity which is offered or participated in is recorded.

The physical environment

Ward 3 is located on the lower basement floor in the main hospital building. The layout of the ward consisted of six single rooms with toilet facilities, and two dormitories which could be used for either three or four individuals at a time. The dormitories had toilet and shower facilities shared by the occupants. There was one additional shower for use by the individuals in the single rooms and a separate bathroom.

The open plan lounge/dining area was bright and cheerfully decorated for the Christmas Fayre, however we wondered whether there had been any material changes made to this area and felt with the removal of the festive art, this had not been addressed since our last visit.

Adjacent to this room was a small garden with several benches and large planters. We were told that this was a popular area and well used in the summer months and there were plans to repaint the seating when the weather improved to keep this area a pleasant asset for individuals and their families.

In the ward, a new nursing station had been completed to improve observation of the individual group however, we observed a distinct lack of dementia friendly signage around the ward which made orientation difficult. The dormitories listed the names of individuals, and the single rooms had a picture with a name included on a sign on the door. The general manager told us that improved signage was on order, and they were still awaiting delivery, so would monitor and hasten as necessary. We found little in the way of personalisation in the bays or single rooms but were told that the health foundation had been secured to do something “bespoke and interesting” to supplement the hospital estates painting work that was completed on a rolling contract basis.

The SCN told us of ongoing attempts to access charity funding to make additional improvements to the environment and there was planning for repurposing of rooms to increase the effectiveness and ambience of the environment.

Summary of recommendations

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Any other comments

It was reassuring to note that the individuals we met highly praised the staff. Despite having no warning of the visit, the team managed this very well and continued to support individuals and their relatives in the preparation for and then during the Christmas Fayre event. The funds raised from this event were to be used for individuals who would be in the ward during the festive period.

We met a newly formed nursing team who were keen to make improvements and we recommended that with the number of changes being brought in, there was a need to ensure staff understood why changes were needed to help keep them motivated and involved.

A notice board strategically placed directly outside the staff room displayed thank you cards from relatives with the aim of reminding staff the purpose of their role and who was central to all they do. One newly registered nurse told us that they had chosen to be on that specific ward, enjoyed their job and felt supported through the mentoring system that had been adopted.

Another positive change was the improvement in family contact. We saw a notice board listing upcoming meetings and there was also feedback forms actively seeking involvement and

participation. There was an information sheet available with lots of pertinent information such as how to access the spiritual care team and facilities, however, it was printed on one page, so it was difficult to read due to the font size; we were aware that one individual had specific vision problems and would have been unable to read this. This could easily be remedied by increasing the font size and printing it in a leaflet or booklet style to make this helpful information more accessible for individuals and families.

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