Mental Welfare Commission for Scotland

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

Date of visit: 28 March 2024

Where we visited

Ward 1, the intensive psychiatric care unit (IPCU) at St John's Hospital is a 10-bedded, mixed-sex unit. It also has an enhanced care suite for any individual who requires additional support during their stay in hospital.

An IPCU provides intensive treatment and interventions to individuals who present with increased level of clinical risk and require enhanced levels of observation. IPCUs generally have a higher ratio of staff to individuals and a locked door commensurate with the level of risk being managed in an intensive care setting. It would be expected that staff working in IPCUs have skills and experience in caring for acutely ill and often distressed people.

On the day of this visit to Ward 1, there were eight individuals in the ward.

Who we met with

We met with six people and reviewed the care notes of five. We also spoke with relatives following the visit to Ward 1.

We spoke with the service manager, clinical nurse manager, the senior charge nurse, charge nurses and consultant psychiatrist. We also had an opportunity to meet with and have feedback from psychology and the arts psychotherapist.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

As visitors to this ward, we witnessed an IPCU that was calm, where staff were confident and caring during their interactions with individuals.

We recognised that some individuals were experiencing significant mental ill health issues at the time of our visit. Despite this, we felt it was important to gather their views about their care and treatment in Ward 1.

We heard from individuals that their experiences were positive; they told us "staff are lovely", "staff are great, really supportive and I feel included in my care". For some individuals they did not always feel involved in their care, and as such, there were times where they felt staff were not specifically asking for their views about what was important to them in terms of their recovery.

For relatives, we heard they felt involved and included in conversations and discussions about their relatives' care and treatment. This was important to them as previously, this had not always been their experience. We had the opportunity to meet with and hear the views of allied health professionals who provide input into Ward 1. We were told, "clinical decision making tends to be done in a very thoughtful way, consistent with least restrictive option and is genuinely person-centred and recovery-focused".

We were advised that Ward 1 is working towards accreditation for inpatient mental health services (AIMS). This is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Through regular reviews, the ward had achieved many of the standards set by the Royal College of Psychiatrists and the intention was to complete the programme to achieve Level 1 accreditation.

Care, treatment, support and participation

We wanted to review care plans during this visit, as we had identified areas in care planning that required attention and improvement. This was in relation to care plan reviews and updates where required. On this visit to Ward 1, we still found that care plans were not regularly reviewed, nor did they identify specific goals to aid recovery. We found care plans that were generic and not specifically person-centred.

This was in direct contrast to the detailed risk assessments, one-to-one sessions with staff and therapeutic interventions/sessions with members of the multi-disciplinary team (MDT). We would like to have seen where a care plan had been reviewed that it was amended when specific goals had been accomplished, and that it identified which member of the team had supported individuals with their recovery. Initial information that would allow the reader to understand the purpose of an individual's admission to an intensive care setting would be useful; a description that provides this context is essential due to the nature of an IPCU, and which identifies the restrictions placed upon individuals who are deemed to require this type of environment.

Recommendation 1:
Managers should ensure nursing care plans are person-centred, contain individualised information, and evidence individuals' participation in the care planning process.

Recommendation 2:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of 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

Care records

Documentation relating to care was mostly held on the electronic system used in NHS Lothian, TRAKCare. We found care records easy to navigate and found all relevant information to support our visit.

Similarly to our last visit to the ward, would like to highlight the good standard of record keeping in individuals' continuation notes. It was apparent the clinical team, including nurses and allied health professionals who updated care records, knew their patients very well. With daily detailed accounts for each patient held in their electronic care record, it was easy to identify where there had been steps towards recovery and the times where patients had required higher levels of support, as well as the outcome from supportive interventions.

In the records, there was a subjective view from individuals, a note of interventions that had been helpful and strategies agreed to aid recovery. This was further extended to seeking individuals' views in relation to the weekly multidisciplinary team meetings, with a focus upon gathering an individuals' perspective about their recovery and next steps. While we were pleased to see the ward-based team had adopted an inclusive approach to record keeping, we were disappointed to find rather non-specific terms to describe individuals' presentations. For example, "low profile, visible and evident around the ward" were used in the records. This appeared to again be in contrast with the good examples of detailed narratives mostly found in continuation notes.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) consisting of nursing staff, psychiatry, psychology, occupational therapy, pharmacy, and activity coordinators. There was regular input from disciplines such as art and music therapists, and referrals to other services were made when required.

We were pleased to hear there was a drop-in service from a substance use service; this was welcomed by individuals and the clinical team, as it is recognised individuals could, and did, present with mental ill-health with co-existing substance use, and required additional expertise from practitioners to provide support with harm-reduction and stabilisation.

The MDT met weekly to discuss individuals' progress and to hear the views from individuals and their relatives. We heard individuals had an opportunity to meet with nursing staff prior to the weekly meeting; this was considered essential as it ensured individuals were offered time to discuss their goals, what was working well and any unmet needs that required additional attention.

To support a whole team model of care and treatment, each individual had a team formulation. Psychological formulations are beneficial for the individual and staff as they provided an understanding of presentation and behaviours. The MDT had been focusing upon reducing restrictive practice, improving engagement, and adopting a model of care that promoted relational security. This was an important development for the team, as it recognised that an individual's recovery could be influenced by staff attitudes and culture. Staff had ongoing support and education to provide trauma-informed practice to the people in their care, while also having opportunities to engage in their own, or in group reflective practice sessions with a psychologist. We were told this had helped when engaging in one-to-one work with individuals and in identifying those people who required additional enhanced support. Where an individual had experienced a possible distressing episode, or where staff had had to deliver enhanced support to an individual, there were formal opportunities to engage with 'de-brief' sessions. We were told those sessions had become invaluable for individuals and staff based in Ward 1. Having opportunities to explore emotional responses to incidents and events allows everyone to consider how to support each other and for individuals to express their anxieties and worries in a safe space with staff who are trauma-informed and compassionate.

Use of mental health and incapacity legislation

On the day of this visit, all eight people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) or subject to the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act).

All documentation relating to the Mental Health Act and Criminal Procedure Act was available on TRAKCare electronic care records system.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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 in place where required and corresponded to the medication being prescribed.

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 all of the relevant paperwork.

Rights and restrictions

Ward 1 continued to operate a locked door, commensurate with the level of risk identified in the patient group. There was a locked door policy in place to support this.

For individuals who had opportunities to have time off the ward, we found detailed pass plans that were updated where necessary. Furthermore, we found specific care plans in each

person's records that ensured they were aware of their rights. Where an individual, who by virtue of their mental ill health, required additional support with understanding their rights and the required restrictions placed upon them, they were provided with regular opportunities to discuss any issues or concerns with nursing staff. Those discussions were clearly evidenced throughout individuals' care records.

When we are reviewing patients' files, we look for copies of advance 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. Health boards have a responsibility for promoting advance statements. We note that due to each patient's mental state at the time of being in an IPCU, it may be difficult to complete an advance statement, however, we would suggest that it would be possible to begin discussions with an individual about developing an advance statement. We were pleased to see in individuals' care records, evidence of advance statement discussions, and this was further explored throughout their admission to Ward 1.

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.

Activity and occupation

We heard from individuals and staff how much they valued the recreational and therapeutic activities available in the ward. There was a recognition from the MDT that activities played an important role in helping an individual's recovery, while also providing opportunities to learn new skills.

There was a diverse range of activities, from more formal support of art and music psychotherapy to physical exercise and recreation. Occupational therapy was also recognised as an essential provision for individuals admitted to this ward. Occupational therapists had a dual role in that they undertook functional assessments and ensured therapeutic activities were provided to promote mental and physical well-being.

We were pleased to hear the activities coordinators offered a full range of activities seven days a week and this was extended to the evenings too.

The physical environment

The ward was closed for a period to carry out essential maintenance work. The team took this as an opportunity to re-fresh and update existing rooms, as well as to create a family room to provide a space for young visitors and their families. The ward was a bright and welcoming space, and we were pleased to see that the team had taken time to create a softer environment, with the intention to promote a sense a calmness. By inviting individuals who were admitted to the ward to engage in the process of creating a new therapeutic environment, there was a sense of well-being and comfort.

The ward had 10 single bedrooms with en-suite facilities, which offered individuals privacy. There were quiet areas when the level of clinical activity was high. We found the communal areas of the ward bright and spacious with recreational options including a pool table, gym,

sitting rooms with 'mindful' activities available for individuals who preferred less energetic activities and an outdoor space when the weather was favourable. We were informed there was an intention to update the outdoor space; we agreed this would be beneficial. In its current state, we would propose it was not a particularly inviting space to spend time in.

While the communal areas of the ward and individuals' bedrooms had been refreshed and were considered comfortable, the room temperature of the bedrooms were repeatedly raised as a concern. Furthermore, individuals told us the bedding supplied by the hospital was very uncomfortable and was not fit for purpose. The blankets provided were thin, did not provide any warmth and individuals had brought in their own duvets to ensure they were warm during the night. We found this situation unacceptable; we brought this to the attention of the senior leadership team on the day of the visit. This situation requires immediate attention as individuals should not feel it necessary to bring in their own bed linen from their homes in an attempt to keep warm and comfortable overnight.

Any other comments

Intensive care environments need to balance safety along with a therapeutic model of care and can become overly restrictive with little flexibility in their delivery of care and treatment. We found that similar to previous visits to Ward 1, staff have continued to provide a model of care that was holistic, trauma informed, and person-centred. Due to the team's endeavour to understand the complex nature of individuals' presentations and build on a relational secure model of care, there were very good examples of positive engagement with individuals and their relatives. This relationship between the ward-based team and individuals meant there was a degree of flexibility that invited staff and individuals to be equal partners. Psychoeducation was evident, and this extended to individuals admitted to Ward 1 and all professionals tasked to provide care and treatment. The focus upon learning and standard setting that was apparent during our previous visits was again noted during this recent visit to Ward 1.

Summary of recommendations

Recommendation 1:
Managers should ensure nursing care plans are person-centred, contain individualised information, and evidence individuals' participation in the care planning process.

Recommendation 2:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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