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: 30 May 2024

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 bedrooms.

We had been informed of the intention to reduce the number of beds in the ward in line with current recommendations to consider a move from ward-based care and treatment to community mental health services. The ward had commenced the process of bed reduction from 24 to 22 and will further decrease numbers over the next few weeks. The ward-based team also recognised that reduced bed capacity would increase staffing availability to support individuals admitted to the ward. We last visited this service in June 2023 on an unannounced visit and made recommendations on care planning and the requirement for regular reviews to reflect progress and outcomes. We also made a recommendation on supporting individuals to understand their detention status, including whether they were in hospital as informally. We received a detailed action plan from the service and regular updates throughout the year.

On the day of the visit, we had the opportunity to meet with several staff from the multi-disciplinary team including the senior charge nurse, charge nurse, clinical nurse manager, general manager, consultant psychiatrists, psychology and student nurses.

Who we met with

We met with four people and we reviewed their care records. We also spoke with two relatives on the day of the visit. We met with the senior leadership team prior to the visit to Ward 17 and had the opportunity to discuss our initial findings with them at the end of the day feedback session.

Commission visitors

Anne Buchanan, nursing officer

Lesley Paterson, senior manager (east team)

Jo Savege, social work officer

What people told us and what we found

People we spoke to were positive about their experiences in Ward 17, telling us that the "nurses have been amazing", "nurses find a way to help with activities, they make it happen" "the team have been so good and I feel safe here" We also had the opportunity to speak with relatives, who were equally positive, "my relative couldn't get any better treatment, anywhere", the staff have been "superb".

We often ask whether relatives are kept informed of progress or invited to engage with meetings to discuss their relative's care and treatment. We were told by relatives from the point of admission they had felt "involved", and that "everything was explained", and that they had felt supported which was important, as this had been their first experience of adult mental health services.

We also had the opportunity to speak with student nurses on placement in Ward 17. The ward had offered a range of learning experiences, mentors were supportive and working with the multidisciplinary team (MDT) had been beneficial to understand a MDT model of care and treatment.

Care, treatment, support and participation

During our last visit to Ward 17 we were told there were several individuals admitted to the ward who would usually have been admitted to Edinburgh inpatient mental health services. Individuals continued to be admitted to Ward 17 due to capacity issues in the Edinburgh services. While the situation was not ideal, we were told by the senior leadership team based in St John's Hospital that communication between services, including community mental health services throughout Lothian had improved. We also asked individuals about their experience, and whether they would have wished to be placed closer to their home locality. While an admission to hospital in Edinburgh would have been preferrable, most individuals felt their admission to Ward 17 had been largely positive due to staff support, the range of activities on offer and the ward environment.

Multidisciplinary team (MDT)

On the day of the visit there were 22 people receiving care and treatment in Ward 17. Each individual was discussed at the weekly MDT meeting, and they had their own senior doctor overseeing their treatment. At the time of our visit, there were five senior doctors working across both inpatient and community mental health services. We were told this model lent itself well to continuity of care for individuals and their relatives.

There were several allied health professionals providing input for individuals in Ward 17. For individuals who required additional support from allied health professionals', referrals were made to specific services, such as, physiotherapy, dietician or speech and language therapy. While providing care and treatment specific to their expertise, each MDT member provided weekly feedback to the MDT meeting outlining an individual's progress. We were told by nursing staff they have received additional training to enhance their nursing skills. This included a more psychological approach to working with patients who have experienced trauma. Individuals had input from psychology where there was an emphasis on psychological

formulations. Psychological formulations were helpful for the individuals, their relatives and staff, as they provided an understanding of presentation and behaviours.

Engagement with families and relatives

There had been a focus upon ward-based staff strengthening their links and communication with relatives, which was evident through our conversation with families on the day of our visit. The team recognised the importance of inviting relatives to engage in meetings and reviews and this had been welcomed by relatives as they now felt their views were heard and responded to. The ward-based team had reiterated their commitment to improve communication and extend this to their colleagues throughout Lothian to ensure pathways from hospital-based care to the community were seamless.

Care records

Of the individuals we met with, we reviewed their electronic care files. All clinical documentation was stored on TrakCare. We found the electronic records easy to navigate and were pleased to find all documentation was secured safely on one system. We found the daily recording of progress notes to be detailed, with 'canned text' used to support staff to ensure the key areas in a patient's presentation were accounted for. Both subjective and objective narratives were captured throughout individual's care records, from one-to-one sessions with nursing staff, to engagement with members of the MDT. We enjoyed reading information from contact with individuals, particularly during discussions around progress and achieving goals that enabled recovery.

Care records included a wide range of assessments from functional assessments undertaken by allied health professionals, risk assessments and risk management plans detailing how the identified risks were managed. It was clear the MDT model of care and treatment lent itself well to supporting individuals to understand their mental ill-health, scope for recovery and staying well in the future. Where individuals required a degree of restrictive practice, this was communicated to them with regular reviews and amendments where necessary. This way of engaging with individuals promoted person-centred care and treatment. We appreciated that while all record keeping was held electronically, we would have expected individuals receiving care and treatment to have access to their individualised care plans. We were aware the service was identifying ways they could provide a 'copy' of a care plan for individuals to refer to and we look forward to viewing hard copies of paperwork for individuals during our next visit to Ward 17.

Use of mental health and incapacity legislation

On the day of the visit, seven people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Of those individuals 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 individuals, 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 and authorised treatment correctly.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this in the individual'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 individuals 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 people who were not subject to Mental Health Act legislation and were accepting their care voluntarily, they were uncertain of their detention status and whether they were in hospital voluntarily or formally.

Recommendation 1:
Managers should ensure individuals are informed of their detention status and that information is provided to ensure all individuals 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 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. Where specified person restrictions were in place under the Mental Health Act, we found all authorising paperwork was in place.

When we are reviewing each individual's file, we looked 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 found leaflets and posters on display to promote advance statements and where an individual had written a statement, we found those in their care records.

We noted that all individuals had access to independent advocacy. This provision was offered by advocacy staff in-person, with individuals provided with opportunities to meet with advocacy at a time that was convenient for them. Individuals could ask for support from this service for a range of issues or for support during mental health tribunal hearings. Equally, to ensure individuals had access to legal representation, nursing staff supported them to maintain contact with their legal representative. Mental health officers also provided support and guidance in relation to Mental Health Act hearings.

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 were pleased to hear there were two activities co-ordinators who were supernumerary to the ward's nursing establishment. We were told this ensured their time was dedicated to organising ward-based and community activities. This also extended to a gardening project that individuals could continue to attend following their discharge from the ward. We were told individuals not only enjoyed ward-based activities but, also having many opportunities to attend various groups and activities away from the ward too. Individuals were supported to engage with therapeutic activities provided by art therapy, occupational therapy, and allied health professionals.

For individuals 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 because of dormitory style rooms that were not en-suite, with only a few single en-suite bedrooms. Individuals told us they would like to have been given a choice whether they had a single room or share a dormitory with other people. We heard that sharing a dormitory could impact on an individual's sleep pattern and could limit their privacy. We were told by the senior leadership team that with the intention of reducing available beds in Ward 17, there would be scope to provide additional space for individuals. This will also provide additional space for members of the MDT too.

The ward continued with its updating programme of work and we found the ward to be bright, clean and welcoming. With new furniture in communal areas and additional new furniture on order we could see there was an ongoing commitment to ensure ward 17 was a therapeutic environment. We received feedback on the day of the visit from individuals and their relatives who described the environment as "great" and "felt welcoming" during visits to the ward.

Summary of recommendations

Recommendation 1:
Managers should ensure individuals are informed of their detention status and that information is provided to all individuals to ensure they are fully aware of their legal status and their rights.

Service response to recommendations

The Commission requires a response to this recommendation 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 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.

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