Mental Welfare Commission for Scotland

Report on announced visit to: Ward 17, St John's Hospital, Livingston EH54 6PP

Date of visit: 25th October 2017

Where we visited

Ward 17 is the adult acute admission ward for West Lothian. There are currently 24 beds, with a combination of four dormitories and six single rooms. There are separate dormitories for men and women.

The clinical team consists of psychiatry, nursing and occupational therapy. If input is required from psychology and physiotherapy, referrals are made accordingly. Art therapy is being trialled for a six month period and there is daily (Monday to Friday) input from the local gym staff and a benefits advisor.

This was an announced visit. Our last visit to the service was unannounced on the 27th of October, 2015, although Ward 17 was visited as part of adult acute themed report in 2016/2017.

Recommendations from the visit in 2015 were in relation to an audit of the nursing care plans and the storage of forms for authorising medical treatment.

On this occasion, we were interested in reviewing the care plans, the legal documentation and activities that are available for patients.

Who we met with

We met with eight individuals on the day, and reviewed their care plans. We also met with the senior charge nurse (SCN), the clinical nurse manager (CNM), the service manager (SM), the consultant psychiatrist and the activities coordinator.

Commission visitors

Ian Cairns, Social Work Officer

Claire Lamza, Nursing Officer (visit coordinator)

What people told us and what we found?

Care, treatment, support and participation

The people that we met with, on the whole, described positive experiences of the care they had received while in the ward; we were made aware of one instance where a patient had experienced care that they had been unhappy with. This was raised with the SCN on the day of the visit.

We were told that staff were approachable and supportive, although a few people told us that there did not seem to be enough staff and that they had to seek staff out. We were advised that there are at least five staff per shift, and we observed that the staff are visible because of the location of the main nurses' station. We found evidence of one-to-one sessions, but the recording of these sessions in the care plans was inconsistent. We would recommend that a different approach be considered to

establishing dedicated one-to-one sessions so that patients who request these are aware, in advance, of times when they can meet with their key/named nurse.

Recommendation 1:

The SCN should routinely review the recording of one-to-one sessions as part of the care plan audit process. A system should also be developed where one-to-one sessions are organised and provided for those patients who have identified that they would prefer for staff to approach and meet with them.

We were made aware that there had been a recent change in paperwork and that some of the care plans have not yet been changed to the new Royal Edinburgh and Associated Service (REAS) documentation. In the care plans that we reviewed, we found that care and treatment was well defined. The care plans were organised, with colour coded sections dividing the different aspects of care. The documentation provided clear evidence of the admission process, a weekly care plan review with personal goals and a seven day treatment plan. We found that care goals were person centred and that there was a detailed review with what had worked well and what could be changed.

We found evidence of participation, with patients signing their care plans and the weekly review that noted the patient's view of their care. There was also evidence of a ward community meeting for patients to discuss their views and carer involvement in the care review meetings. There is a helpful leaflet with information for patients that gives details about staff, treatment and activities, the routine of the ward and the ward vision.

Use of mental health and incapacity legislation

For the individuals that we met with and whose care plans we reviewed, we found all of the relevant documentation relating to the Mental Health Act in the defined section. There was a useful form (the heading on the form was The Mental Health (Care and Treatment) (Scotland) Act 2003), that detailed which section of the Mental Health Act was applicable, along with the date of when a period of detention began. These forms were completed accurately for the patients that we saw who were formally detained. We also noted that there were social circumstances reports available, and the consent to treatment forms (T2), were kept with the medication recording sheets.

There is a section on the Mental Health Act form that notes whether an advance statement has been written, but these were not completed in any of the care plans that we reviewed.

Recommendation 2:

The named nurse/key worker should complete the advance statement section on the relevant form and where there is no advance statement, information should be provided about this for future consideration.

Rights and Restrictions

One of the patients that we met with had support from advocacy and access to legal representation. The other patients that we spoke to were aware of the advocacy service. There were posters available on notice boards throughout the ward and contact details for the service were included in a leaflet that contained a range of helpline numbers, which is given to patients at the time of admission.

Where there were restrictions in place, these were again noted on the Mental Health Act form and the relevant documentation filed in the patient's care plan. There was also a copy of the notification to the patient and their right of appeal.

We also found clearly defined levels of observation. Changes to the patient's observation status were documented as part of the weekly review along with the discussion held with the patient. We noted that risk assessments were individualised and these were reviewed and updated regularly.

Physical Environment

Ward 17 is on the second floor, so there is no direct access to a garden area or outside space. The day areas are spacious and these are separated to provide a range of activities – the dining area is separate from the pool table/recreation space. There is also a gym, laundry and several quiet areas for patients to access.

However, some of the furnishings are dated, some of the equipment, such as the table tennis table, is broken and the ward is in need of redecoration. We were advised that an upgrade of the ward is scheduled for next year and that a project team is soon to be established to oversee this work. This work will also ensure that the environment is safe from ligatures.

In discussion with the SCN and the CNM, we were made aware of the issue of out of area boarding, which can have a detrimental impact on the ward. At times, Ward 17 receives patients from Lothian, Tayside and Perth but also patients who should be in the West Lothian older adult service, Ward 3, are placed in Ward 17. One of the patients that we met with noted that at times, the mix of patients created a challenging environment that led them to feel unsafe; they said that the lack of single room accommodation compounded this. Consideration should be given to use of the patients safety climate tool.

Recommendation 3:

The CNM should review the out of area admissions to Ward 17 with a view to keeping out of area admissions to a minimum.

Activity and occupation

Of the patients we spoke to, nearly all described a range of different activities that was on offer on a daily basis. One of the patients spoke positively about the new life skills

that they had been able to develop while in the ward. A sheet that gives examples of a weekly activity programme and a wall board with the day's activities is available for patients.

It was noted earlier that the ward has no direct access to an outside space, however, the occupational therapy staff and the activities coordinator facilitate daily walks. They also facilitate breakfast and lunch groups, relaxation and mindfulness groups, art therapy and psychoeducation/therapy groups. There are external organisations that visit the ward, such as narcotics and alcoholics anonymous, staff from a local gym. Another valuable resource is an advisor who assists patients with advice about their benefits.

We were impressed with the variety of activities available for patients in Ward 17. On the day of our visit, there were six different groups taking place. We had an opportunity to speak to the activities coordinator, who is a band 6 registered nurse, specifically employed to provide a range of individual or group based interventions, accessible during the week and at weekends. The groups can be recreational, activity based, or have a focus on psychological wellness.

Any other comments

We were made aware of a significant adverse event that had taken place a few days prior to our visit. Several of the patients that we spoke to told us of the incident, but they explained that this had been dealt with promptly and that the staff on duty had been responsive, and supportive, to their needs. We also noted that the SCN had conducted a prompt, thorough review and included the full clinical team in this process; we received feedback that the staff who were involved in this adverse event, felt very supported.

Summary of recommendations

1. The SCN should routinely review the recording of one-to-one sessions as part of the care plan audit process. A system should also be developed where one-to-one sessions are organised and provided for those patients who have identified that they would prefer for staff to approach and meet with them.

2. The named nurse/key worker should complete the advance statement section on the relevant form and where there is no advance statement, information should be provided about this for future consideration.

3. The CNM should review the out of area admissions to Ward 17 with a view to keeping out of area admissions to a minimum.

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.

Alison Thomson
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 MWC 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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