

Mental Welfare Commission for Scotland

**Report on announced visit to: Ward 3, St John's Hospital,
Livingston EH54 6PP**

Date of visit: 16 March 2017

Where we visited

Ward 3 at St John's Hospital is a 12 bedded acute mental health admissions unit for adults over the age of 65. The ward is based on the lower ground floor of a district general hospital. We last visited this service on 10 March 2016 and made recommendations about care plans, multidisciplinary record keeping, legislation requirements to facilitate discharge, section 47 certificates and person-centred activity plans.

On the day of this visit we wanted to follow up on the previous recommendations and also look at other issues related to the environment and the mix of patients with dementia and functional mental illness. This is because we are often made aware of the significant challenges of meeting differing needs and that staff can be stretched trying to achieve this.

Who we met with

We met with or reviewed the care and treatment of nine patients and met with the relatives of three patients.

We spoke with the service manager, the ward manager, the occupational therapist and one of the consultant psychiatrists.

Commission visitors

David Barclay, Nursing Officer and visit co-ordinator

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

On the day of the visit we met initially with the service manager and ward manager, who informed us of the changes that had been taking place in relation to ward 3 and other mental health wards on the St John's Hospital site. There are significant challenges for the service, as being part of a district general hospital means that beds occasionally have to be used for patients who have initially been admitted to a general ward but are then transferred to ward 3 as they will also have a diagnosis of dementia or delirium. The inpatient liaison nurse being co-located on the ward helps with the management of this process. There is also the issue of patients whose discharge is delayed as they no longer require to be treated in an acute hospital but there is a lack of care home beds in West Lothian.

Care Plans

There have been updates to the care plans and multidisciplinary team (MDT) records since our last visit. We saw some improvements in the care plans, which are more person-centred and address content from the risk assessments and weekly MDT reviews. However, not all of the care plans we reviewed were person-centred. We found files containing incomplete mental health care plans and some which were lacking in detail of the kinds of interventions to be used. It was also difficult to identify if patients or carers were involved in the writing of the care plans or reviews as there was no evidence of their involvement in the care plan formulation.

Recommendation 1:

Managers should audit nursing care plans to ensure consistency in recording and review. Care plan reviews should be meaningful, include the effectiveness of interventions and reflect any changes in the individuals care needs. The patient's participation in care planning should be evidenced in the care file.

Multidisciplinary team Input

MDT meetings take place each week on the ward for each of the four consultant psychiatrists that cover Ward 3. We were pleased to see progress in how these meetings are more consistently recorded in the care files, with the names of all attendees, meeting outcomes, future plans and how this information links to patients care plans. It was easy to identify from this document what legislation may need to be considered and implemented to allow someone to be moved to alternative accommodation – this was an improvement from the last time the Commission visited.

Relative and carer feedback

We met with the relatives of three patients, they all commented favourably about the care and treatment provided by the clinical team on Ward 3. They spoke of being fully involved and informed of the treatment for their relative and plans for follow up. Staff were seen as easy to approach for advice and support and they encouraged carers' attendance at the MDT meetings and discharge planning meetings. There was some positive feedback about the various activities available to patients and how this seemed to help people to feel more settled – they commented on how relaxed and comfortable people seemed to be on the ward.

One to one input

All patients on Ward 3 have a key worker and associate nurses that oversee their nursing care and treatment. We expected to see evidence of patients having one to one sessions with the main keyworkers recorded in the care file, although it was not possible to identify these sessions taking place as they were not highlighted as one to one sessions. This was disappointing as there was evidence in the file of significant

nurse/patient interaction and we found that the nurses we spoke with were knowledgeable about the patients in their care, and they appeared to have established therapeutic relationships with them. Properly recorded one to one sessions aid the care planning process and inform the MDT of what further input is necessary to assist the person towards recovery.

Recommendation 2:

Managers should ensure that the one to one sessions which take place regularly are recorded and easily identifiable in the care file.

Use of mental health and incapacity legislation

Mental Health (Care and Treatment) (Scotland) Act 2003

On the day of the visit there were three patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. The detention paperwork was held on the TRAK electronic record keeping system but there was a helpful checklist at the front of the care files that detailed the type of detention, renewal dates and other information regarding the detention. The patients that required T2 or T3 consent to treatment forms had these, and copies of the forms were also kept with the person's medicine prescription sheets, which covered all of the prescribed psychotropic treatment

One person's medicine prescription sheet had 'if required' intramuscular medication (IM) prescribed, despite being there as an informal patient. We have concerns about intramuscular 'if required' IM medication being prescribed for informal patients. This is because it is likely that they would not be consenting to receive the treatment if it was later administered. We consider it best practice for a medical review to be arranged if circumstances arise where intramuscular medication may be required. In acute admission wards, administration of "if required" IM psychotropic medication almost always requires the legislative authority of the Mental Health Act.

Therefore, we consider that IM "if required" medication should not be prescribed for informal patients, other than in exceptional cases where staff and a known patient are clear that it is for use in known circumstances where the patient expects they would consent to the treatment. Even then, staff and the patient should be clear that they can withdraw their consent at any time. This was raised with staff on the day, and as a result, the medical staff discontinued that drug.

Recommendation 3:

Managers should ensure that intramuscular "if required" psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances.

Adults with Incapacity (Scotland) Act 2000

There were no patients on the ward who were subject to welfare guardianship. Staff were aware of the process of welfare guardianship being undertaken for one patient.

Consent to treatment documentation

Several patients had s47 certificates in place where they lacked capacity to consent to treatment for physical health issues. We noted that there was a significant improvement in the quality of information recorded on these compared to what we found on last year's visit. The forms had more detail about what treatment was covered and they all had accompanying treatment plans.

Rights and restrictions

Ward 3 has a locked door which requires a swipe card to exit – there was a locked door policy in place and staff can let patients out who need to get out for a walk in the grounds or to go to the hospital shop.

Activity and occupation

Ward 3 benefits from the input of an occupational therapist (OT) four days per week with an OT technician on three of those days – activities are available Monday – Friday, day time only. Patients reported positively of the activities on offer. There are impromptu activities on evenings and weekends facilitated by nursing staff depending on staffing and other ward routines. The activities board used pictures to help those individuals with cognitive impairment know what was available. Person centred activity plans were in place in each patient's care file, with evidence of active participation in group and individual sessions. These care plans were well written and were reviewed weekly at the MDT meeting. We felt that the activities on offer were more suited to patients with a dementia illness and raised this with the OT. We were told that the activities are continually reviewed for appropriateness for the patient group and adapted where needed.

The physical environment

The ward seemed dated and in need of upgrading. Managers highlighted that it requires substantial renovation works including work to reduce the risk from ligature points, in common with the other mental health wards at St John's Hospital and this is planned for the next financial year. It was noted that the ward seems stark and clinical. There were a few historical pictures of the local area from the 1930's and 40's, which were interesting and an attempt to make the ward feel more homely but we noted that these were very small and placed quite high on the wall in one part of the corridor. Some areas of the ward were pleasant and comfortable including the quiet sitting area

and the therapy kitchen, though on the day of the visit we felt these areas were underused.

The environmental issues highlighted at last year's visit have started to be addressed. The small outdoor courtyard has been made more secure with a screening fence providing privacy. However, this has delayed the area being ready as extra funding to complete this work needed to be applied for. This has allowed the original funding to be spent on high quality benches and planters. We look forward to seeing how this outdoor area can be used to offer additional occupational activity and a pleasant outdoor alternative quiet space once it has been completed.

Summary of recommendations

1. Managers should audit nursing care plans to ensure consistency in recording and review. Care plan reviews should be meaningful, include the effectiveness of interventions and reflect any changes in the individuals care needs. The patient's participation in care planning should be evidenced in the care file.
2. Managers should ensure that one to one sessions take place regularly and that these are recorded and easily identifiable in the care file.
3. Managers should ensure that intramuscular "if required" psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances.

Any other comments

The relatives and carers we met with were appreciative of the care and support of nursing staff. We witnessed empathic interactions between staff and patients during our visit. Nursing staff highlighted that it appears that patients with functional mental illness do not get the same level of nursing interaction due to the demanding nature of providing nursing care to patients with dementia illnesses. This is recognised by managers and there is ongoing discussion about the possibility of the service moving to an ageless model of care. We look forward to hearing how this develops at future visits.

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.

Mike Diamond

Executive Director (Social Work)

3 May 2017

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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