



Mental Welfare Commission for Scotland

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

Date of visit: 26 February 2019

Where we visited

We last visited this service on 16 April 2017. Ward 3 at St John's Hospital is a 12-bedded acute mental health admissions unit for adults over the age of 65. On the day of the visit there were 13 patients, as the bed normally reserved for ECT treatment was being used. The ward is located on the lower ground floor of a district general hospital. In our last report, we made recommendations about care plans, recording of one-to-one sessions with patients, and the use of intramuscular medication.

On the day of this visit, we wanted to meet with patients, follow up on our previous recommendations, and to look at other issues relating to the environment and the mix of patients with dementia and/or a functional mental illness. This is because we were made aware of the significant challenges of meeting the differing needs of a mixed patient group.

Who we met with

We met with five patients and also reviewed the care and treatment of a further eight patients.

We spoke with the clinical nurse manager, senior charge nurse, medical staff and occupational therapist.

Commission visitors

Susan Tait, Nursing Officer
Moira Healy, Social Work Officer
Tracey Ferguson, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

From the patients we spoke with who were able to give us a view, we were told that staff were helpful and usually available. We saw nursing staff interacting and engaging well with patients. In discussion with nursing staff, they appeared knowledgeable about patient needs and strengths.

One patient had concerns and expressed their discontent at being in a ward with patients who had dementia, as they found it difficult to deal with this when a high level of distressed behaviour was exhibited. From our previous visit, we were aware of the challenges of having an acute admission ward with patients who have a functional mental illness and dementia. This has not changed since the last visit in 2017 and presents continued concern. We discussed this with senior staff on the day and they advised that an improvement plan is in place for Ward 3, which includes reviewing the mix of patients.

On our last visit, we identified that care plans lacked person-centred information and appropriate review. We were told in response to this recommendation that this had been addressed. However, we found current care plans that we reviewed not to be particularly person centred. They were not descriptive of the interventions required to provide individualised care, particularly in relation to mental health. Physical health care plans were more detailed. There was little evidence of patient participation in care planning, although some of the care plans had been signed by the patient.

In the last report, we highlighted that one-to-one nursing meetings with patients were not evidenced. We were told in the management response to this that this had been rectified. However, we found it difficult to identify this in the notes we reviewed. We were able to see that patients were reviewed regularly by the multidisciplinary team and this was generally well recorded.

Recommendation 1:

Managers should review the remit of the ward to consider the differing needs of patients.

Recommendation 2:

Managers should audit nursing care plans to ensure that they are person centred and descriptive of the interventions required. Where possible, participation should be evidenced.

Recommendation 3:

Managers should ensure that one-to-one sessions with patients are recorded to evidence both participation and nursing input.

Use of mental health and incapacity legislation

On the day of our visit some patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Most of the patients met the criteria for treatment under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). Consent to treatment forms (T3) under the Mental Health Act were in place where required, although one patient had been prescribed medication not covered by the T3. This was raised with staff on the day.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of 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.

Section 47 certificates were difficult to find and the ones we did review were out of date, resulting in patients being treated without lawful authority.

Recommendation 4:

Managers should ensure that all consent to treatment forms under mental health and incapacity legislation are in place where required and authorise the treatment prescribed.

Rights and restrictions

Access in and out of the ward is via a locked door. In our last report, we noted that a locked door policy was in place. However, on the day of our visit, this was not displayed to inform patients how to leave the ward and to inform visitors of the importance of closing the door.

In the previous report we had concerns about the prescribing and administration of intra-muscular injections on an 'as required' basis. We were told that this practice had stopped, which concurred with our findings on the day.

The Mental Welfare 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.

This can be found at <https://www.mwcscot.org.uk/rights-in-mind/>

Activity and occupation

Ward 3 benefits from a full-time occupational therapist (OT) and a part-time occupational therapy assistant. In the last report we highlighted that most activities seemed to be focussed on patients with dementia. We were able to see that the OT had introduced an activity board with pictorial representation of the activities offered which would benefit patients. We were able to see that a person-centred programme had been developed for one patient with anxiety, and that a new recording sheet of activity recording had been introduced. There is also therapist input, with two dogs visiting on a regular basis.

The physical environment

The ward is spacious, which has advantages, but poses challenges in ensuring that patients are observed appropriately. There is an accessible patio which is well utilised. The environment does not have a particularly welcoming appearance, being somewhat stark and clinical. This was commented on in the last report. We were told that new furniture had been ordered and was due imminently. There are two lounges which we felt could be used to afford patients with differing needs a more dedicated space. There is a kitchen which has been upgraded and is available to patients at most times. There were plans to provide a picture board to inform visitors and patients how to identify staff.

Recommendation 5:

Managers should review the current environment to consider how it may be both more welcoming for patients and how the space might be reassigned to meet the needs of the patient mix.

Summary of recommendations

1. Managers review the remit of the ward to consider the differing needs of patients.
2. Managers should audit nursing care plans to ensure that they are person centred and descriptive of the interventions required. Where possible, participation should be evidenced.
3. Managers should ensure that one-to-one sessions with patients are recorded to evidence both participation and nursing input.
4. Managers should ensure that all consent to treatment forms under mental health and incapacity legislation are in place where required and authorise the treatment prescribed.
5. Managers should review the current environment to consider how it may be both more welcoming for patients and how the space might be reassigned to meet the needs of the patient mix.

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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