Mental Welfare Commission for Scotland

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

Date of visit: 26 November 2024

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Ward 3 is a mixed-sex admission unit located in St John's Hospital, Livingston, which primarily provides assessment and treatment for adults over 65 years from the West Lothian area who experience functional or organic illness. It has 12 beds with the additional capacity of two surge beds when needed.

On the day of our visit, there were 13 people admitted, one who was out on a pass to their home. There was a total of four people categorised as having their discharge from hospital delayed. Delayed discharge occurs when an individual is clinically ready, although unable to leave hospital due to a lack of available care, support or accommodation. We were told that those who were delayed were waiting for care home placements.

We last visited this service in December 2023 on an unannounced visit and made recommendations in relation to person-centred care planning, family/carer involvement and participation, risk assessments, promotion of advance statements and recording of activity provision. The service responded with actions planned to address the recommendations.

Who we met with

We met with the general manager (GM), clinical nurse manager (CNM) and senior charge nurse (SCN) remotely via a Microsoft Teams meeting prior to our visit.

On the day, we met with seven people and reviewed the care and treatment of four people and spoke with two relatives. Due to the extent of the symptoms of their illness, some individuals were unable to have a conversation with us, however, we were able to observe everyone at different points throughout the day. The environment appeared settled and calm.

Additionally, we were able to have discussions with medical and nursing staff and the activity co-ordinator when they were engaging with individuals. The SCN was available throughout the day and the CNM attended the ward during the visit. The GM joined the feedback meeting later in the day along with the senior team members.

Commission visitors

Denise McLellan, nursing officer

Sandra Rae, social work officer

What people told us and what we found

The feedback from individuals and relatives was positive. One person told us that “all staff are approachable, nurses, occupational therapists, activity co-ordinators. The doctor is wonderful, really listened.”

Another person who was admitted several weeks before felt satisfied so far during their admission and told us that they regularly attended the multidisciplinary team (MDT) meeting as they wished to be fully consulted about their care and treatment. They described it as “daunting” but felt that it was essential to remain fully involved. They informed us that staff were “really supportive” and while activities were available, none met their interest. However, they acknowledged that staff did continually try to identify new interests. They valued staff visits to their room where they preferred to spend the day reading, adding that this was supportive. They also appreciated being supported to spend time away from the ward, which was an enjoyable interaction for them.

One individual spoke of being content on the ward and said there were plenty of activities available and that staff were “excellent and supportive.” They spoke of frequent one-to-one interactions and how these were not rushed. They also benefitted from regular family contact. They had an awareness of their rights in relation to their care and treatment, however, understood that they needed additional support before they could be discharged home. It was evident they felt this admission had provided benefit and they praised their consultant psychiatrist saying, “he brought me back from the brink.”

Further feedback was provided by someone who spoke of attending meetings with doctors, some of the nursing staff and family members. They described this as an opportunity to discuss how things were going and how to move forward. They said they found this was a helpful way of telling the team how they were feeling. They felt comfortable with the pace of their plan of gradual progression towards discharge and were aware of their rights, however, were happy to remain on the ward until the team felt they were ready to go home. They also spoke of being able to share any concerns and how these would be resolved. They understood that they could approach whomever in the team available in the moment of needing to discuss anxieties and this included the occupational therapist (OT) and activity co-ordinator in addition to nursing staff. They were unable to recall whether they had participated in developing their care plan or what the specific goals of the admission were.

Further feedback described the food as “very good, especially the soup” and that sufficient variety was available. They described staff approaching them regularly to advise of activities available, “there was quite a lot on.” Having to share a shared sleeping area was “alright” and they described communal areas as being “pleasant”.

Someone else who had recently been admitted described their dormitory as "peaceful, with no animosity." They said the food was “palatable” however, preferred to use the hospital canteen for lunch every few days as this was an opportunity to spend time with their spouse away from the ward. They did not feel restricted by ward routines and found staff “very helpful.” They highlighted an issue which could have been potentially very embarrassing for them; however, nursing staff had managed the situation in such a way, providing reassurance that they had not been inconvenienced which was “emphasised amazingly.” Further to this, the person had observed that nursing staff were respectful and helpful towards each other as well as individuals receiving care. Although they felt there was a variety of activity offered, they suggested some may appreciate having musical instruments available.

One family member spoke about difficulties arising from their relative’s delayed discharge due to waiting for transfer to long term care. The family view was that although social work remained involved to progress this, contact was infrequent, and they felt that the process was not working. They spoke of attending at least four family meetings with numerous professionals, however, due to their relative’s complex health issues there was ongoing delay finding a viable long-term placement. We discussed this with the SCN who confirmed that previously there had been a designated social worker for the ward, however, due to changes made to provision and reduction in social work staffing, this had led to some gaps. Assurance was offered that people were being reallocated a new social worker.

They also described a good level of information sharing by the team and a willingness to have problems resolved quickly, specifically commenting that they found the SCN very supportive. They told us there was a positive atmosphere that fostered where people could be open and where they were welcomed to share any concerns. They described this as “a partnership with staff” adding “it’s been so tough” and “they all know how to manage and keep them occupied.” They told us that nursing staff engaged with their relative with “warmth and understanding.”

Other feedback included “the ward’s wonderful, but sometimes there’s not enough staff for the amount of work needing carried out.” Relatives spoke of visiting regularly and getting to know the staff, praising their ability to manage care and the importance of having the right people with the right training. They offered an example where they felt listened to after a difference of opinion and felt this was managed professionally and with a timely response. They felt encouraged to share information about their relative and were made to feel that their own knowledge and experience was valuable and that they were all trying to work together to achieve the best outcome for individuals. They also commented that they felt kept informed by the team.

Other positive aspects about the ward included that family had a certain “peace of mind” knowing their relative was being care for; “certain nurses have a special attitude and understand the challenges that come with mental illness as well as physical health problems.” The staff who worked there regularly were described as “excellent.”

Although the ward itself was settled during our visit, we heard several safety activation alarms initiated throughout the day. We learned that nursing staff responded to all psychiatric emergencies within the main hospital and saw the designated responder having to leave the ward frequently due to high levels of clinical activity elsewhere in the hospital. Additionally, although bank shifts could be booked in advance for foreseen absence, where shortages were unexpected, staff provided cover to the intensive psychiatric care unit (IPCU), general adult psychiatry ward, regional eating disorder unit (REDU) and mother and baby unit (MBU). Nursing staff also covered short falls arising at the specialist dementia wards at the Craigshill facility and Tippethill Hospital.

We had an opportunity to meet with medical staff who told us about ongoing challenges in relation to recruitment and the lack of clinical psychology provision to the ward. Further details of these concerns are documented within the MDT section of this local visit report.

Care, treatment, support, and participation

We found evidence of physical health care monitoring including diabetes, medication and side effect management, routine and additional physical observation monitoring (temperature, pulse and respiration), skin integrity, continence, fluid and nutrition. Individuals could also access the gym located in Ward 17. The emphasis on this aspect of care and treatment was positive to see, given the significance of physical health in older people with dementia.

We noted that a named nurse system was in operation and that there were regular one-to-one contacts with nursing staff. Anxiety management was provided by the occupation therapist (OT) as needed.

We noted examples of where staff supported individuals at their own pace rather than attempting to deliver care in a task-oriented manner. We could see where relatives/carers had been consulted and their knowledge of the individual respected, as well as an example of respecting an individual’s wish not to share information with others where indicated.

We were pleased to see the emphasis given to maintaining an important relationship for one individual. Daily visits were facilitated so that this person could see their spouse, who had been admitted to a ward elsewhere in the hospital. The significance and impact of this could not be underestimated for this individual.

Important information was gathered from individuals or relatives where necessary by using 'What matters to you' and 'Getting to know me' documentation. Welfare proxy and family views were also recorded. We noted involvement with family at meetings that occurred on a two-monthly basis and some relatives/carers attended MDT meetings with individuals.

A welcome pack had been developed, with guidance to aid orientation to the ward, as well as additional helpful contact details for organisations such as Alzheimer Scotland, Carers of West Lothian, and the Commission. Some of the information printed was out of date so would benefit from review. A leaflet providing information on EARS independent advocacy service was also available.

Care records

Individual records were located on the electronic health record management system TrakCare. It held information about assessment, the MDT meeting record, risk assessment, continuation notes, recording of one-to-one contacts and mental health care plans. In the main, care records we reviewed were comprehensive and we could see that nursing staff knew the individuals well and had endeavoured to consult them. We found documented evidence of regular one-to-one contacts.

On previous visits, we had been advised that TrakCare was not intuitive when writing comprehensive person-centred mental health care plans. We were pleased to see that improvements had been made. We found examples of care plans that were up to date and informative and gave a real sense of inclusion in the ward. We found these to be more individualised and could see where individuals had participated with setting personal aims, although we would like to have seen more detail in some care plans.

We saw printed information in the form of a flow chart displayed on the duty room wall providing guidance on the writing of care plans and were told that person-centred care plans (PCCPs) were audited fortnightly using a digital quality management tool. PCCP updates were available; however, we needed assistance to locate these as only the most recent reviews were displayed. Earlier updates were still available via the audit tool changes which showed previous actions. There appeared to be an increase in participation from individuals compared to our previous visit.

Other records included 'do not attempt cardiopulmonary resuscitation' (DNACPR) certificates which were all completed accordingly. The MDT meeting records were thorough and well documented, providing prompts for discussion including legal status, advance statements, specified person restrictions, assessments and interventions planned, psychological needs, capacity assessment, authority to treat, referrals for specialist treatment, covert medication pathways, palliative care

reviews, medicine of the elderly involvement, family views, MDT discussion and follow up actions.

Multidisciplinary team (MDT)
The MDT consisted of psychiatry, medical staff, mental health nursing, student nurses, clinical support workers, OT, OT assistant, activity co-ordinator, pharmacy and a dietician. Referrals to physiotherapy and other disciplines could be made as necessary.

Changes to social work allocation had resulted in some gaps, with no designated social worker for a period of time, but we were told that people were now being allocated to new social workers. We were advised that this discipline was represented in all MDT and family meetings. Links with community mental health teams (CMHT) helped to promote continuity in care. We heard from one individual who explained that this had been helpful and enabled a quick admission to the ward.

Improvements had been made to the recruitment and retention of nursing staff, however, one of the Band 6 charge nurses had recently taken a post elsewhere and this vacancy was being recruited to. We were disappointed by the lack of clinical psychology provision to the ward since the withdrawal of this service during the Covid-19 pandemic. Psychology provides a valuable contribution to the MDT, and it was understood this gap increased the pressure for psychiatry and nursing. Some anxiety management was being delivered by the OT, and we were told that individuals could be referred to the meaningful activity centre (MAC) in the hospital when experiencing stress and distress.

On our last visit we were told the process to acquire clinical psychology provision had commenced, however, the vacant post was still awaiting job evaluation which had been further delayed by staff absence. Given the wards remit to provide assessment and treatment for functional and organic illness, this was concerning in respect of the lack of individual psychological therapies and assessment and training around the 'Newcastle model of care' for stressed and distressed behaviours. Concerns were expressed about the further impact delays could have on people's mental health, where depression could develop secondary to this and lead to people being detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). There was also frustration that prolonged hospital admission could lead to other medical problems.

Recommendation 1:
Senior managers must progress securing dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and individual groups.

We met with medical staff during our visit and heard of difficulties relating to a longstanding vacant consultant psychiatrist post. It had been covered for a few months intermittently by locum psychiatrists, and consideration was given to factors why individuals may be deterred from pursuing this vacancy. Although it covered a small sector, the job plan had been changed to include extra sessions for a sector-based model of inpatients and outpatients. The remit also encompassed hospital based complex clinical care (HBCCC) at the Maple Villa (Craigshill) and Rosebury (Tippethill House) facilities. Another potential factor influencing appeal appeared to be related to the on-call rota.

We were told the West Lothian rota differed to the pan-Lothian one and that this could be challenging given the diversity of specialities, such as the mother and baby unit, the eating disorder service, as well as older adult and general adult psychiatry and there was contemplation about whether removing this obligation could make the post more attractive. We heard that the liaison service was split over two posts due to recruitment challenges and was covered by locum staff. It was felt there was competition from other posts across the Lothian area with other positions considered more appealing.

Recommendation 2:
Senior managers should seek resolution regarding the longstanding consultant psychiatry vacancy through further consultation to achieve a wider understanding of the barriers in recruiting to this role so that a permanent solution can be achieved.

When reviewing the records, we saw that the structured MDT meeting questionnaire generated discussion around discharge planning, recording of attendees and where individuals had participated in meetings. There was discussion about social care needs including packages of care, benefits and accommodation. MDT meetings occurred twice weekly, so everyone's care was discussed on a weekly basis. The consultants participated collectively feeling there was educational value in doing so. As well as contributing to peer support, it provided an informal means of cumulative expertise with informal second and third opinions, especially given the mixed admission criteria. This was also helpful during periods of leave where cover was necessary.

Although there was provision for 12 beds, capacity was often at 13 and 14 which could feel unmanageable and very stressful. Another emerging concern stemmed from what appeared to be a lack of understanding by medical unit colleagues of how physical health could be managed in this setting given the frailty and chronicity of individuals in the ward. There was a gap in medical cover, as there was no general practitioner (GP) or advanced nurse practitioner (ANP) provision, but we were told that the ward had been shortlisted for ANP funding.

The team had access to a named consultant geriatrician who was described as approachable and contactable by email but there was no set timeframe for input and the medical registrar could be contacted for more acute problems. Otherwise, there was no formal medical cover in Ward 3. Attempts had been made to secure provision from the REACT hospital home team, however, they did not have sufficient resource, and the team struggled to find a solution to this problem. We heard that although able to give pastoral support, consultants were unable to offer clinical support to the three resident doctors who could be second year foundation doctors (FY2) or core trainees.

A recent case review highlighted a situation where an individual with chronic health problems experienced a rapid deterioration. Psychiatry did not feel they had the expertise to manage this and sought transfer of the individual to a medical bed where the person could be managed more effectively. The findings were that although the delay in transfer to the medical unit had not influenced the outcome in this case, it highlighted wider concerns about the provision of medical care to the psychiatric unit.

Recommendation 3:
Senior managers should ensure the gap in medical cover is addressed so that individuals are given equitable access to reduce the risk of further deterioration in their physical health.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health Act. We were told there was a focus to be 'paper light'. Some legal paperwork was held in a folder, in addition to being held on TrakCare, but this was not entirely consistent. However, we did find all relevant authority in place and available on SCI store.

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. We found consent to treatment certificates (T2) and one certificate authorising treatment (T3) under the Mental Health Act were all available and in place where required.

For individuals subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) we found copies of welfare guardianship orders (WGO) and power of attorney (PoA) certificates within the paper files for most people. We were unable to find one PoA certificate and one WGO certificate and were told that both had been hastened, and certificates were awaited.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found certificates in place with the corresponding treatment plans; however, one of these failed to record the date of the medical examination. Generally, there had been discussion with the relatives apart from one, where there was no record of the PoA being consulted.

Recommendation 4:
Senior managers should ensure that regular audit is introduced out to ensure that information within s47 certificates is accurate and complete.

Rights and restrictions

Ward 3 operated a locked door policy commensurate with the level of risk identified. Information was displayed which provided a clear explanation of this. Everyone we spoke with said they were aware of their rights and for those admitted to the ward on a voluntary basis, we found them to have a good understanding of the purpose of their admission and informal status.

They told us they knew they could leave the ward and had never encountered any problem doing so but were happy to remain for care and treatment. We were told of close links with EARS independent advocacy and were able to see current involvement when reviewing the files.

Activity and occupation

The ward had a dedicated full time activity co-ordinator who worked closely with the OT and OT assistant. The co-ordinator would meet with individuals to discuss activity, and we could see that participation was actively encouraged. Nursing staff were responsible for this provision when the co-ordinator was not on duty.

A weekly planner was displayed and there was a variety of activity available including music, pet therapy, a pool tournament, baking, arts and crafts, sudoku and dominoes. On the day of our visit the ward was actively preparing the environment for the St. Andrew's Day event planned for the weekend. Scottish music was playing in the background, and individuals appeared engaged in creating artwork which would be used to decorate the communal areas for the event. We were told that endowment funds had been used to purchase supplies for this activity.

Where we had spoken earlier with one individual who struggled to participate in these activities, we could see evidence of them being supported to regularly attend the hospital gym, as was their preference. We also learned that the SCN was passionate about increasing pet therapy and was researching and attempting to source additional provision to include pony therapy.

The physical environment

Ward 3 was located on the lower basement floor in the main hospital building. The entrance to the ward was welcoming, clean, bright and spacious with a large amount of information displayed on wall boards. We also noted the addition of a suggestion box aimed at relatives/carers. The wall boards included comments from relatives and student nurses who had enjoyed placements in the ward, and this helped foster a safe and pleasant ambience. Corridors were also decorated with artwork and had information to help identify staff on duty.

The layout of the ward consisted of six single rooms with ensuite toilet facilities, and two dormitories which could be used for either three or four individuals at a time. The dormitories had shared toilet and shower facilities. There was one additional shower for use by the individuals in the single rooms and a separate bathroom. The nurses' station was positioned for support improved observation.

The ward was spacious and benefitted from a community hub, an OT therapy kitchen relaxation room, an open plan sitting and dining area and a small garden which could be accessed from the main sitting area. A pool table had been added to the quiet room. Other modifications had been made since our last visit, and we were shown new plastic anti-ligature ward rails and curtains had also been fitted. However, there was minimal signage to help orientate people, which was especially important as individuals on this ward had mixed diagnoses. We were told that dementia-friendly signage had been ordered, and this was expected soon.

Some effort had been made to help individuals identify their single rooms with the inclusion of pictorial laminated sheets attached to the doors and names added. We were told that additional funding had been applied for to make further improvements to the environment.

We asked whether nicotine therapy (NRT) was offered, given that the law extending the prohibition of smoking within 15 metres of an NHS Scottish hospital building was brought into effect in 2022. We were told that although this was actively offered, it was not always accepted, and individuals were permitted to smoke in the garden area when they did not have time away from the ward. We raised our concerns about this with senior managers and will continue to monitor this matter.

Recommendation 5:
Senior managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this. Smoking cessation interventions should continue to be promoted.

Any other comments

It was clear the individuals we spoke with felt supported and respected by the clinical team and this included relatives who gave very positive feedback. We also noted that the ward had recently been awarded ‘ward of the month’ and they were proud of this achievement. Some concerns in relation to gaps in provision were highlighted and we will continue to monitor this situation.

Summary of recommendations

Recommendation 1:
Senior managers must progress securing dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and individual groups.

Recommendation 2:
Senior managers should seek resolution regarding the longstanding consultant psychiatry vacancy through further consultation to achieve a wider understanding of the barriers in recruiting to this role so that a permanent solution can be achieved.

Recommendation 3:
Senior managers should ensure the gap in medical cover is addressed so that individuals are given equitable access to reduce the risk of further deterioration in their physical health.

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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 an individual's care, treatment, and support are 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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