Mental Welfare Commission for Scotland

Report on unannounced visit to:
St John's Hospital, Adult Rehabilitation Service, Pentland Court, Livingston EH54 6PP

Date of visit: 18 March 2025

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

Pentland Court is the mental health rehabilitation service that covers West Lothian area of NHS Lothian. The unit is based in the grounds of St John's Hospital, Livingston and has the capacity for 10 individuals, offering mixed-sex accommodation comprising of flats shared by either two or three individuals.

We last visited the service in February 2023 and made two recommendations, firstly in relation to each flat having access to white goods including washing machines and secondly, there were areas in each flat that required updating and upgrading.

We received an action plan from the service advising that both recommendations were completed and further upgrading of each flat and communal areas had also been completed following our last visit.

Who we met with

On this recent visit we had the opportunity to meet with one individual, nursing staff and the senior leadership team. As the visit was unannounced, we were aware several individuals were attending pre-arranged placements or were unable to meet with the visiting team on the day. Similarly for relatives too.

We advised the ward-based team, should individuals or their relatives wish to speak with the Commission, we would be happy to accommodate this at a time suitable for them.

We reviewed the care of four individuals, including the individual one we had met in person. We had the opportunity to discuss care and treatment with the ward-based team.

Commission visitors

Anne Buchanan, nursing officer

Lesley Paterson, senior manager (east team)

What people told us and what we found

We meet with nursing staff on the day of the visit to Pentland Court, and heard there had been significant staffing challenges over the past year with senior nursing staff and registered nursing staff absence for various reasons.

The current compliment of nursing fell short of the usual nursing establishment, however the current team remained committed and focused to deliver care that promoted recovery and independence for people admitted to Pentland Court. While there was accepted limitations to this due to a reduced staffing establishment, nursing staff along with allied health professionals were keen to maintain community connections that would support and encourage successful discharges from hospital-based care back into the community.

We heard referrals into Pentland Court came from a diverse range of services, notably the general adult services had been the primary referrer. This has now extended to medium and low secure mental health inpatient services. While Pentland Court provided care and treatment in the unit, its aim was to promote opportunities for individuals to reintegrate into their communities across West Lothian. By having links with various support agencies across the local authority, individuals could expect to have input from statutory and non-statutory organisations.

Care, treatment, support, and participation

We reviewed the electronic care records which were held on TRAKCare and found examples of detailed and person-centred care plans which addressed a range of mental health, physical health and the more general health and well-being of the individual.

While we found examples of person-centred care planning, this was not consistent throughout all the records we reviewed. We would like to have seen evidence of where staff and individuals had met to agree goals for recovery, who from the clinical team was supporting any interventions and when reviews took place to consider progress.

We appreciated there may be some individuals who were not keen to engage in specific conversations in relation to goal setting and this should be acknowledged in their care record. Where individuals had provided input into their care planning, again this should be evidenced and any amendments or updates to care plans identified.

We would propose particularly in specialist rehabilitation wards, engagement with individuals to support recovery and independence is essential. We found goals to support rehabilitation lacked definition and detail. We would expect to have found care goals in reference to physical, psychological, mental, therapeutic, financial, social, recreational and vocational needs, while taking into account the individuals'

strengths and skills that had been maintained throughout their admission to hospital.

Recommendation 1:
Managers should ensure that care plans and their reviews are person-centred and meaningful. Reviews should include the effectiveness of interventions while reflecting any changes in an individual's care needs.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

We were told that while the ward had dedicated input from a consultant psychiatrist, access to daily medical cover was not available. This situation was brought to our attention during our last visit to Pentland Court in February 2023. Medical cover was available through the 'duty doctor' system which nursing staff advised us had caused possible delays in relation to immediate access to medical staff and accessing medication.

We heard that individuals who required medical attention could access this through primary care services, for example a GP. We were told that nursing staff had been encouraged and supported to attend additional training to meet the physical and wellbeing needs of individuals in Pentland Court. We would like to have seen more information as to how physical wellbeing had been supported in individuals' care plans. We recognised for many people who experience serious and long-term mental ill-health, their physical well-being can be compromised for a host of reasons and health inequalities remain a national concern.

Where we saw care plans that included physical well-being as a need, interventions from allied health professionals were in place, and this included dietician, physiotherapy and occupational therapy (OT).

We were advised that all individuals admitted to Pentland Court were supported to have access to NHS national screening programmes that they would have in the community for example, breast, cervical, and bowel screening.

We were told individuals had opportunities to attend a range of community groups and organisations. We were pleased to hear while there had been some challenges for non-statutory support services in relation to continued funding, largely this had not compromised access to the many organisations available in West Lothian. During our visit, we heard that staff were committed to working alongside community groups and services. This was particularly important for individuals who had experienced a degree of isolation prior to their admission to hospital. There was

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

a recognition that recreation and social connection with peers in the community had a positive impact on maintaining recovery and staff investment was a priority to ensure individuals were able to attend support groups and therapeutic sessions.

There were ongoing challenges in relation to individuals' discharge from hospital-based care into the community. There were two individuals' whose discharge had been delayed for an extended period. The term 'delayed discharge' refers to when a person who is clinically ready for discharge from inpatient hospital care, continues to occupy a hospital bed, usually because of delays in securing a placement in a more appropriate setting. Delayed discharges impact negatively on the individual who is delayed, maintaining active engagement in terms of ongoing rehabilitation can be difficult if discharge dates are not confirmed.

We were advised that the delays to discharge were mainly in relation to securing appropriate housing and care packages in the community. Furthermore, applications for welfare guardianship under Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) legislation had caused additional delays.

The ward-based team recognised they could not influence the length of time these processes were taking. Nevertheless, they often had to manage individuals' daily frustrations in terms of delays and communication from the local authority, including housing teams. On review of the care records, we could not find a consistent approach to communication with local authority teams. We had expected to find regular updates including timeframes for actions and where timeframes had not been achieved, the justification for this.

Recommendation 2:
Managers should ensure there are clear communication pathways between the clinical team and local authority services, including social work and housing departments. That communication should be evidenced in individuals' care records and where possible regular updates provided to reduce the risk of continued, unnecessary delays.

Care records
Care records were held in TRAKCare electronic record system, with continuation notes that included a 'canned text' framework with specific areas of focus including general presentation, activity, physical health, medication, current risk or any changes to the risk assessment.

We saw evidence of one-to-one meetings between nursing staff and individuals. Those meetings included areas of particular focus included in the canned text framework however, we would have liked to have seen where individuals had been invited to share their views of progress and where they had felt their recovery was not progressing as they would have liked. We did see where staff had taken time to

meet with individuals and their relatives and were working with and supporting relatives and carers, which was important for the ward-based team.

There were several documents held in the TRAKCare electronic record system; those included assessments, risk assessments, physical well-being charts, measuring tools in relation to medication management, legal paperwork and accompanying documentation.

We were able to access several assessments undertaken by members of the multidisciplinary team (MDT). Those included functional assessments carried out by allied health professionals (AHPs), for example occupational therapists (OTs), physiotherapy, dietetics service, who had an important role in relation to supporting individuals to develop healthy meal choices to improve overall well-being.

Multidisciplinary team (MDT)
There were two MDT meetings held each week to review care and treatment of everyone in Pentland Court. On the day of the visit, we saw evidence of the mental health structured ward round document in use, which was held in individuals' care records. This document provided a framework for review discussions, along with progress and any actions deemed to be necessary to support individuals. Unfortunately, while we saw there were twice weekly meetings taking place, we were unable to find any records of who attended the meetings, for example nursing staff, AHPs, community staff, including those from the local authority.

There were some documents that were completed in detail however, this was not consistent and would have benefited from an audit to determine whether essential information was captured in the document and in terms of input into the meetings, were key personnel invited to attend and provide regular updates.

Recommendation 3:
Managers should consider undertaking an audit of the MDT meeting process to ensure key professionals are invited, their attendance recorded, and timely updates are provided to inform the wider clinical and local community services who are providing input for individuals.

We heard that the ward's substantive OT was highly valued, with their assessments and care plans influencing strategies to aid an individual's recovery. We were also informed the OT had plans to develop their role and input into the ward to further support individuals and work alongside nursing staff to continue with a holistic model of care and treatment.

The ward did not have regular input from psychology. During our last visit to Pentland Court, we were told by individuals and their relatives that people had benefitted from psychological input that had been available for them. We understand

from visiting individuals in specialist rehabilitation services that having opportunities to engage with a psychologist had been described as a positive experience.

Furthermore, for staff having opportunities to be involved in creating psychological formulations gave them a greater understanding of an individual's needs in relation to building therapeutic relationships. As individuals and their relatives had previously mentioned, access to psychology was an important part of their recovery. We asked staff whether this would or could be facilitated; we were told only individuals who were currently engaged with psychology prior to their admission to Pentland Court had access to psychological services. This service would not be extended into the unit to meet the potential needs of the current inpatient population.

Use of mental health and incapacity legislation

On the day of our visit to Pentland Court, two individuals were subject to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act). Part 16 of the Mental Health Act sets out 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 where required and corresponded with the medication being prescribed.

We reminded the ward-based team where certificates authorising treatment (T3) had been updated, having those uploaded into an individual's electronic care records was an important safeguard.

On the day of the visit to Pentland Court we were told there were two individuals who were subject to AWI Act legislation. We asked to review the individual's legal paperwork including powers granted in the welfare guardianship order. We asked the ward-based staff which powers had been delegated to the ward-based team and how this had been agreed between the guardian and staff. Unfortunately, on the day of the visit we could not locate AWI Act paperwork, and this included section 47 certificates which may have been necessary to authorise treatment when an individual had been assessed as lacking capacity to make decisions about their welfare.

We were aware that nursing staff on the day of the visit perhaps did not fully appreciate their responsibility in relation to understanding the AWI Act as a legal framework. We discussed why it is necessary to have legal paperwork stored correctly and ensure that nursing staff are aware of delegated powers and how those are reviewed if necessary.

Recommendation 4:
Managers should undertake a training needs analysis to determine the training needs of staff working with individuals who are subject to the AWI Act.

The Commission has worked jointly with NHS Education for Scotland (NES) to develop training in relation to the AWI Act and an eLearning module has recently been launched on TURAS. This can be accessed by anyone in the workforce and has been developed for those working with people aged 16+ years who may be considered to lack capacity to make some or all decisions.

Rights and restrictions

There was easy access in and out of Pentland Court, and individuals had their own keys to the unit and their flat. Pass plans were in place for individuals that indicated what level of support they needed when out with the unit.

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 a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of the visit there were no individuals requiring to be specified, however, staff told us of the possible vulnerabilities of one individual who may not be able to safeguard their interests. On this occasion we advised the ward-based team to review the individual along with the consultant psychiatrist to assess for any risks that may compromise the individual and their relationships. We were told the individual had been a specified person until recently and may require additional restrictions again.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 one advance statement in the records we reviewed.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

Nursing and OT staff continued to support and encourage individuals to attend community-based support groups. This was to ensure individuals had ongoing access to enhance their daily living skills and could access creative and recreational activities. Additional access to health promotion and social activities was also regarded as a priority to reduce the risk of health inequalities and encourage social connections with peers once discharged from hospital.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Unfortunately, Pentland Court did not have a dedicated activities co-ordinator and that ward-based activities were described as 'ad-hoc' and undertaken by staff when time allowed. The OT had the intention to commence a programme of activities that would be available for those on the ward and that would also build on daily life skills to support recovery.

The physical environment

Pentland Court offered a mix of shared two/three-bedroom flats, with shared kitchen and living spaces. There was a further 'activity' flat that offered a space for individuals and staff to undertake functional assessments, group work and build on daily life skills.

During our last visit to Penland Court we noted there were several areas in the unit that looked rather tired and required updating. We were pleased to hear there had been a programme of works to update several areas of the unit and with the addition of new furniture, the unit looked clean and well-maintained.

Outside the unit was a pleasant courtyard with seating, which when the weather allowed, was used for socialising. While the unit was based in the grounds of a large hospital campus, there was easy access to a local recreational park, bus services into town for shopping and a GP practice for individuals who required primary care services.

As part of an individual's rehabilitation, staff were able to support people in relation to independent travel on public transport to various support groups across the county. This was considered an important step to enable individuals to build confidence, skills and a level of independence.

Any other comments

We wish to acknowledge the ongoing commitment the service had made over the past year to support individuals with their rehabilitation and optimising their potential for recovery. Having many competing demands and limited staffing resources has made the past year, at times, rather challenging.

We were told by staff we met with that in the absence of a consistent nursing establishment, supporting individuals had limited the potential for intensive rehabilitation. This had an impact upon individuals and nursing staff who were keen to invest in the care of people however, this was seen as frequently compromised due to staff shortages. Nevertheless, the core team have demonstrated their determination to provide care, treatment and support to all individuals admitted to Pentland Court.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plans and their reviews are person-centred and meaningful. Reviews should include the effectiveness of interventions while reflecting any changes in an individual's care needs

Recommendation 2:
Managers should ensure there are clear communication pathways between the clinical team and local authority services, including social work and housing departments. That communication should be evidenced in individuals' care records and where possible regular updates provided to reduce the risk of continued, unnecessary delays.

Recommendation 3:
Managers should consider undertaking an audit of the MDT meeting process to ensure key professionals are invited, their attendance recorded, and timely updates are provided to inform the wider clinical and local community services who are providing input for individuals.

Recommendation 4:
Managers should undertake a training needs analysis to determine the training needs of staff working with individuals who are subject to the AWI Act.

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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