Mental Welfare Commission for Scotland

Report on announced visit to:
St John's Hospital, Ward 1, Howden West Road, Howden, Livingston, EH54 6PP

Date of visit: 28 May 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

Ward 1, the intensive psychiatric care unit (IPCU) at St John's Hospital is a 10-bedded, mixed-sex unit. It also has an enhanced care suite for any individual who requires additional support during their stay in hospital.

An IPCU provides intensive treatment and interventions to individuals who present with increased level of clinical risk and require enhanced level of observation. IPCUs generally have a higher ration of staff to individuals and a locked door commensurate with the level of risk managed in an intensive care setting. It would be expected that staff working in IPCUs have skills and experience in caring for acutely mentally unwell and often distressed people.

We last visited this service in March 2024 on an announced visit and made recommendations on providing person-centred care planning while ensuring individuals are invited and encouraged to participate in their own care and treatment. Furthermore, we asked managers to consider regular audits of care plans to ensure they reflected personal progress through the process of regular reviews. We received a detailed response from the service with an action plan to reflect their progress from our last visit.

Who we met with

On the day of the visit to Ward 1 there were five individuals in the ward. We met with three individuals and reviewed the care notes of four. We had the opportunity to speak with two relatives.

We spoke with the service manager, clinical nurse manger, senior charge nurse, charge nurses, consultant psychiatrist. We also had the opportunity to have feedback from psychology and occupational therapy too.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

As visitors to the ward, we witnessed an intensive psychiatric care unit that was calm, and where staff were confident and caring during their interactions with individuals.

We had the opportunity to meet with individuals and speak with their relatives. Individuals told us they had a positive experience of their care and treatment in Ward 1. We were told they have opportunities to work with a range of professionals, which had meant they had also been invited to address their substance use, along with understanding the signs and symptoms of their illness. Working with psychology had been highlighted as a significant chance for people to consider relationships and understanding behaviours that that had caused difficulties in families.

One individual told us they were “deeply grateful” for the care they had received; their admission had not always been easy, however the staff had provided non-judgemental support throughout their admission to hospital. For relatives, having their family member in hospital had not always been a stress-free experience for a host of reasons however, the admission to Ward 1 had improved their views of inpatient care and treatment.

Nursing staff communicated with relatives and regular contact with medical staff had been viewed positively.

Care, treatment, support, and participation

During our last visit to Ward 1, we were unable to find a consistent approach to care plan reviews or evidence of participation between staff and individuals in the creation.

On this visit, we were pleased to have found care planning that was person-centred, with clear evidence of participation between individuals and nursing staff.

We also found care plans that had included evidence of discussions between allied health professionals (AHPs) and psychology. Of the care plans we reviewed, we could see clear links between assessments, including risk assessments and a holistic view of individuals admitted to Ward 1. When discussing a holistic approach to working with individuals we would consider both mental health and physical well-being should be viewed as an essential approach to understanding individuals’ specific needs.

We saw where nursing staff and AHPs had met with individuals to determine specific goals and interventions to enable recovery, both in terms of physical and mental well-being. From our review of care plans, we could see where staff had invited individuals to consider what was important to them and which members of the Ward

1 team would be working with individuals to achieve their goals, identified through continued assessments.

We saw evidence of regular reviews; this was important as achieving agreed goals and updating care plans was essential to ensure progress was recognised. We had the opportunity to review the ward's audit tool which had been in place following our visit last year.

We were pleased to have found the ward had constantly met it objectives to ensure care plans were person-centred with ongoing evidence of individuals participation in their care planning and reviews. We were informed the audit tool included additional dimensions to ensure standard of record keeping was consistently measured and to identify areas that required improvement.

When we review care records and specifically care planning, we look for evidence of carers and family involvement. The recent audit identified care plans and risk assessments lacked consistent carer and family involvement. With the development of the new person-centred care plans on the electronic care record system on TrakCare we were informed there was a specific function available to ensure families are invited to participate in care planning where relevant. We were informed nursing staff, along with medical staff were going to ensure carers and families would be active partners in an individual's recovery

Recommendation 1:
Managers should ensure that carer views and participation are evidenced throughout an individual's care record, including care planning.

We had the opportunity to meet with staff to discuss the new person-centred care plan tool. We could see it was a detailed tool that invited staff to consider specific areas for discussion with individuals admitted to Ward 1. The new format had various headings for example, mental health, stress and distress, activities of daily living, legislation, physical health, risk and activity. Under each heading was a detailed care plan with evidence of reviews, where individuals were given opportunities to discuss their progress and where necessary care plans were amended to ensure they remained purposeful and relevant.

We were told by the team they had welcomed the new care plan tool as it provided a comprehensive approach to promoting a holistic model of care and treatment.

Care records
We were pleased to have found record keeping had remained of a good standard and this included individual's daily continuation notes. Once again, it was apparent the clinical team, including nurses and AHPs who had updated care records, knew individuals very well.

With daily detailed accounts for everyone, it was easy to identify where there had been steps towards recovery and the times where individuals had required higher levels of support, as well as the outcome from supportive interventions. Individuals who are admitted to Ward 1 often require a more detailed risk assessment, typically due to the presentation of their mental illness. Currently TrakCare does not clearly identify past and present risk assessments. While this would not necessarily cause an issue for the reader, it was difficult to identify assessments in 'real time'.

This was also noted by the clinical team who were in discussion with TrakCare administrators to determine whether the risk assessment function could be updated to reflect the distinction between current risks and past risk assessments. We have asked the team to provide an update in relation to progress with this specific TrakCare function.

We could clearly see the links throughout daily continuation notes and care planning. Both subjective and objective views were documented, which allowed the reader to appreciate progress or where the individual required additional support. Throughout individuals' care records, the nursing staff continued to practice a strengths-based, non-judgemental narrative that built on therapeutic relationships to ensure all individuals were provided with person-centred care and treatment.

Multidisciplinary team (MDT)
Ward 1 had an MDT consisting of nursing staff, psychiatry, psychology, occupational therapy, pharmacy and activity co-ordinators. There was regular input from disciplines such as art and music therapists and referrals to other services were made when required.

We were pleased to hear there was a 'drop-in' from a substance use service. This was welcomed by individuals and the clinical team, as it was recognised individuals who present with mental ill-health and co-existing substance use required additional expertise from practitioners to provide support with harm-reduction and stabilisation.

Throughout individuals' care records we were able to locate up-to-date information from social workers based in the local authority. Everyone had regular input from the mental health officer (MHO) who liaised regularly with the clinical team, families and carers.

The MDT met weekly to discuss individuals' progress with invitations extended to social work and community mental health team staff. There was a view individuals should be supported to maintain contact with community services where relevant. We heard individuals were given the opportunity to meet with nursing staff prior to the weekly MDT meetings; this was considered essential as it ensured individuals

were offered time to discuss their goals, what was working well and any unmet needs that required additional attention.

The MDT continued regular trauma-informed team formulation meetings for everyone admitted to Ward 1. With all individuals having access to psychology, having a psychological model, which considered and understood early life experiences and mental ill-health, embedded in the MDT meetings was beneficial in supporting people. For some people admitted to hospital, this may be their first experience of working with psychology. We heard that having opportunities to work with both the ward's psychologist and arts psychotherapist had been transformational in their own understanding of how their mental ill-health had adversely affected them and with an accessible psychological formulation, the team had been able to promote therapeutic relationships to aid recovery.

All staff had ongoing opportunities to attend reflective practice sessions as part of their own personal and professional development. Furthermore, support to attend training for all staff was encouraged as it was recognised by the leadership team that a knowledgeable and skilled MDT was likely to provide care and treatment that was evidence based and credible.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or subject to Criminal Procedure (Scotland) Act 1995 (the Criminal Procedure Act).

All documentation relating to the Mental Health Act and Criminal Procedure Act was available on TrakCare.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, we found the relevant paperwork.

Rights and restrictions

Ward 1 continued to operate a locked door, commensurate with the level of risk posed for most of those in the ward. There was a locked door policy in place to support this.

There were two individuals who were receiving their care and treatment "informally" in Ward 1. There were specific reasons for this, and they had been fully informed of

their rights and restrictions placed upon them due to the ward having a locked door. Both individuals were able to understand their rights and restrictions, and, in both cases, the senior clinical team supported the individuals' requests to remain in the ward until their discharge could be arranged.

For individuals who had opportunities to have time off the ward, we found detailed pass plans that were updated where required. Furthermore, we found specific care plans in each person's records that ensured they were of their rights. Where an individual, who by virtue of their mental ill health, required additional support with understanding their rights and required restrictions place upon them, they were provided with regular opportunities to discuss any issues or concerns with nursing staff. Those discussions wear clearly evidenced throughout individual's care records.

When we are reviewing individuals' files, we looked 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 note that due to each individual's mental state at the time of being in an IPCU, it may be difficult to complete an advance statement. However, we would suggest that it could be possible to begin discussions with an individual about considering an advance statement as their mental state improves. We were pleased to see evidence in individuals' care records of advance statement discussions, and this was further explored throughout their admission to Ward 1.

The Commission has developed *Rights in Mind.*[1] 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

It was evident throughout our visit and discussions with individuals and the clinical team that recreational and therapeutic engagement was highly valued. There continued to be a recognition from the MDT that activities performed an important role in helping an individual's recovery, while also providing opportunities to learn new skills.

There continued to be an interesting and diverse range of activities, from more formal support of art and music psychotherapy to physical exercise and recreation. Occupational therapy was recognised as an essential provision for individuals admitted to the ward. Occupational therapists had a dual role in that they undertook

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

functional assessments and ensured therapeutic activities were provided to promote mental and physical well-being.

We were once again pleased to hear activities co-ordinators offered a full range of activities seven days a week, which extended into the evening too. We were also pleased to hear that volunteers were invited into the ward to engage with individuals. Having opportunities to have connections with the local community was highly valued by the clinical team and people admitted to Ward 1.

The physical environment

The ward was a bright and welcoming space and offered a range of communal rooms and quiet rooms for individuals to relax in. The ward had 10 single bedrooms with en-suite facilities which offered individuals privacy. We found the communal areas of the ward bright and spacious with recreational options including a pool table, gym, sitting rooms with a range of crafting and games to encourage individuals to participate in.

The family room was not in use on the day of the visit due to a maintenance issue with the main door therefore, the family room was used as a temporary entrance into and out of the ward. However, we could see that this room was a comfortable space with a range of soft furnishings that allowed for a safe space for younger visitors to the ward.

The outdoor space was accessed from the ward and would be considered as a courtyard. There had been efforts made to soften the outdoor space with seating areas and plant tubs for shrubs and flowers. The challenge with this area was its lack of privacy, as it was in view of offices and other wards. With that in mind the clinical team had to be aware of their responsibilities to ensure individuals accessing the courtyard would not be compromised.

Good practice

Intensive care wards need to strike a balance between safety along with a therapeutic model of care. Ward 1 has continued to find that balance without being overly restrictive to individuals admitted to the ward. The MDT have continued to make efforts to fully understand the challenges people have experienced throughout their lives and with team psychological formulations there is a sustained position that a trauma informed workforce will enable people to recover and appreciate that they are valued.

Summary of recommendations

Recommendation 1:
Managers should ensure that carer views and participation are evidenced throughout an individual's care record, including care planning.

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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