Mental Welfare Commission for Scotland

Report on announced visit to:
St John's Hospital, Ward 17, Howden West Road, Howden, Livingston EH54 6PP

Date of visit: 3 July 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 17 is the acute admission service covering the West Lothian area of NHS Lothian.

The ward is based on the first floor at St John's Hospital, Livingston and currently has 16 beds offering mixed-sex accommodation comprising of dormitories and single bedrooms.

There had been an intention to reduce the 20 beds in the ward, which had agreed in 2024, however with an unexpected fire in the ward and subsequent damage to a dormitory, the ward has had to reduce their beds numbers to 16 beds. Fire damage to the ward was significant and had required a considerable amount of work to ensure areas affected were repaired and made suitable for individuals admitted to the ward. While the work was being undertaken, the service took the opportunity to update several rooms and provide additional space for the ward-based team to share larger office space.

We last visited the service in May 2024 and made one recommendation in relation to the ward-based team ensuring individuals admitted to Ward 17 were provided with information to confirm they were aware of their detention status and for the team to provide evidence of rights-based care and treatment. We were aware this was the second time we had made this recommendation in relation to rights-based care. We received a detailed response from managers with specific actions to be completed by the service.

Who we met with

We met with, and reviewed the care of five people, four who we met with in person and reviewed five sets of care records. On the day of the visit, we did not have the opportunity to meet with relatives.

We met with the senior leadership team prior to the visit to Ward 17 and on the day of the visit, we had the opportunity to meet with several staff from the multidisciplinary team (MDT) including the senior charge nurse (SCN), charge nurse, clinical nurse manager, occupation therapist, advocacy staff, medical staff and psychology.

We had the opportunity to discuss our initial findings with the senior leadership team at the end of the day feedback session.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

People we spoke with were typically positive about their experiences in Ward 17, telling us that the team had been very welcoming with many opportunities to engage with several members of the ward-based team.

Occupational therapy (OT) was regarded as an important part of individuals' recovery, while having sessions with the ward psychologist was considered very helpful in terms of individuals' understanding of how their past life experiences had shaped their lives. The ward-based nursing team acknowledged reducing the number of beds had given them increased opportunities to engage with people admitted to the ward.

Individuals also acknowledged this as we were told they had appreciated an increase in one-to-one engagement which had been a positive outcome in terms of their recovery. We were told by individuals that they had felt "listened to" and their mental health and well-being had improved due to having a team that were available and approachable.

On the day of the visit to Ward 17, we had the opportunity to meet with advocacy services who provided input to individuals admitted to the ward as well as collective advocacy. We were told advocacy staff felt welcomed onto the ward, nursing staff would regularly refer individuals to ensure they had the opportunity to discuss any issues with advocacy who by virtue of their remit are independent of statutory services. Advocacy were invited to attend MDT meetings, one-to-one review meetings and Mental Health Tribunal for Scotland hearings. This input was important as we were told by advocacy, their remit in supporting people was valued by the service as well as by individuals admitted to Ward 17.

Communication with various members of the ward-based team and the local authority was smooth and timely with regular meetings with to ensure pathways for individuals were unhampered.

Care, treatment, support, and participation

Care records

Individuals' care records were held electronically in TrakCare, which we found easy to navigate. Care records included a wide range of assessments from functional assessments undertaken by allied health professionals (AHPs), risk assessments and risk management plans detailing how identified risks were managed. It was clear to see on this and previous visits that the MDT model of care and treatment lent itself well to supporting individuals to understand their mental ill-health, scope for recovery and staying well in the future.

TrakCare electronic record system did 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 ward-based team who were in discussion with TrakCare administrators to determine whether the risk assessment function could be updated to reflect the distinction between current and historical risk assessments. We have asked the ward-based team to provide an update in relation to progress with this specific TrakCare function.

Throughout individuals' care records, the nursing staff continued to apply a strengths-based, non-judgemental narrative that built on therapeutic relationships to ensure all individuals were provided with person-centred care and treatment.

We found the daily recording of progress notes to be detailed, with 'canned text' used to support staff to ensure the key areas in an individual's presentation were accounted for. We were informed by people receiving care in Ward 17 that they appreciated the opportunity to have one-to-one sessions with nursing staff.

Unfortunately, during our review of care records we saw on several occasions where one-to-one sessions had not been made available to individuals. This was disappointing, as most care plans had documented one-to-one meetings would be regular and made available for all individuals however, this was not always happening. We raised this issue with the leadership team on the day of the visit as it was clear one-to-one sessions with nursing staff were valued by individuals and had been raised as a need that was not always met.

Recommendation 1:
Managers should ensure individuals are offered regular one-to-one sessions with nursing staff and those sessions are documented within the individual's care records.

We were informed there have been a development in terms of care planning with an improved electronic template now in place. While the new template was in its infancy, we could see there were significant improvements in relation to person-centred care planning, with an option to print off a copy of the care plan template which invited active participation between individuals and their keyworker.

Where care plans previously had provided options to consider when discussing the needs of individuals, specific identified goals and agreed interventions, the new care plan had extended the areas of focus to include carers and relatives' engagement, psychological formulations and communication.

Furthermore, there had been an addition to consider legal aspects to care and treatment to ensure individuals were aware of their rights and to promote rights-based care. As previously stated, this new format and template had only been in place for a short period. We are looking forward to reviewing care plans during our next visit to see how person-centred care has been developed further and to receive feedback from individuals and the ward-based team.

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.

Multidisciplinary team (MDT)
On the day of the visit there were 16 people receiving care and treatment in Ward 17.

Everyone had a senior doctor overseeing their care and treatment and was discussed at a weekly MDT meeting. At the time of our visit, there were five senior doctors each having a separate weekly MDT meeting. All senior doctors worked across inpatient and community mental health services. We were told there was one current consultant psychiatrist vacancy yet to be recruited into which had meant for people living in an area of West Lothian they did not have a substantive senior doctor. The gap in consultant psychiatrist provision was being supported by current consultant psychiatrists.

We reviewed several MDT meeting records which were stored electronically on a structured mental health template. The template invited MDT members to discuss a range of areas and was a valuable tool for capturing relevant information from the team, individuals and their relatives.

Unfortunately, we could not see a consistent approach to completing the document. While there were documents that were completed with detailed information, there were several documents that had incomplete or missing information. For example, risk assessment updates were not available or information in relation to engagement with carers and relatives was missing.

We brought this to the attention of the ward-based team as the record of the weekly MDT meeting requires to be accurate with essential information to inform the team of an individual's progress or where amendments to treatment plans are necessary.

Engagement with relatives should also be evidenced as this helps to illustrate how views have been gathered and how relatives are supported to be active partners in their relative's care.

Recommendation 2:
Managers, including senior medical staff should ensure there is a consistent approach to the accurate recording of weekly MDT meetings on the template designed to capture all relevant information concerning an individual's progress in Ward 17.

There were several allied health professionals (AHPs) providing input for individuals in Ward 17. For individuals who required additional support from AHPs, referrals

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

were made to specific services, such as physiotherapy, dietician or speech and language therapy.

While providing care and treatment specific to their expertise, each MDT member provided weekly feedback to the MDT meeting outlining an individual's progress. We were told by nursing staff they continued to receive additional training to enhance their nursing skills. This included a psychological approach to working with individuals who had faced adverse childhood experiences that had had a lifelong impact upon the individual.

For nursing staff, it was acknowledged working in an area which could be unpredictable required all staff to feel supported. The ward-based psychologist provided support through regular reflective practice sessions. For nursing staff, we were told those sessions were invaluable and had provided additional informal education too.

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 that 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.

Use of mental health and incapacity legislation

On the day of the visit, seven people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act)

All documentation relating to the Mental Health 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.

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

Rights and restrictions

During our previous visits to Ward 17 we made recommendations in relation to individuals understanding their rights and any restrictions placed upon them. This was particularly relevant to people who were admitted to the ward and continued to receive their care and treatment informally. Rights-based care has been a fundamental part of mental health care and treatment for many years. It has been recognised that individuals who by virtue of their mental ill-health, and who require

admission to hospital should expect their rights to be at the forefront of any decisions and discussions.

For some people, this may mean they are subject to detention under the Mental Health Act and will have legal safeguards in place. For individuals not subject to a legal framework, they too should be afforded an understanding of their rights. On the day of the visit, we met with individuals who did not require a legal framework to remain in hospital, however, were not aware of their rights or why restrictions had been placed upon them.

This was disappointing to hear as we received a detailed action plan from the service that clearly outlined a system for staff to ensure all people in Ward 17 were aware of their rights either as formal or informal patients. We are therefore having to repeat this recommendation to reiterate to the service that rights-based care should be considered essential and a fundamental basis of care and treatment. We will also follow this matter up with senior managers separately, given the lack of progress in this area.

Recommendation 3:
Managers must ensure there are systems in place to ensure all individuals are aware of their rights, and where restrictions have been put in place, this is clearly communicated to them, their named person and relatives, where appropriate.

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

We were pleased to hear that activity provision was an essential part of enabling an individual's recovery in Ward 17. Individuals admitted to the ward were encouraged to engage in ward-based activities which were facilitated by a range of professionals and volunteers.

While there was a full programme of recreational and therapeutic activities for younger adults admitted to the ward, there was a view that some activities available were not to their taste. We brought this to the attention of the ward-based team as we were aware therapeutic engagement was highlighted through their person-centred care plans.

We met with the occupational therapist, who along with their colleague will meet with individuals to undertake assessments to establish specific areas of need. Functional assessments and outcomes served as a basis to understanding what the individual required in terms of support, their strengths and goals. Daily life skills,

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

budgeting and understanding their own abilities was considered a holistic approach to working with people admitted to the ward. Education was also part of the daily programme, and this looked at psychoeducation, understanding mental health diagnosis, signs and symptoms. Building confidence to aid recovery and relapse prevention was also deemed important.

With both recreational and therapeutic activity provision in place and regular attendance of volunteers into the ward, we found a team who endeavoured to promote meaningful activity for people admitted to Ward 17.

The physical environment

The environment had some challenges because of dormitory style rooms that were not en-suite, with only a few single en-suite bedrooms. Individuals told us they would prefer to have been given a choice whether they had a single bedroom or share a dormitory with other people.

Further challenges were also evident following the significant fire in the ward earlier in the year and the need for extensive repairs to one of the dormitories. Nevertheless, we found a ward that was bright and welcoming. We could see the ward-based team were keen to ensure all communal areas were well maintained, while the domestic staff made considerable efforts to ensure a clean and tidy environment for everyone.

Any other comments

Ward 17 is an example of a multidisciplinary team approach to care and treatment for individuals who require hospital-based care. Each discipline provided input aligned to their professional expertise while also appreciating the need for a whole team approach. Individuals admitted to the ward had opportunities to work with a range of professionals who understood recovery was unique and required investment.

Having skilled staff that appreciated the complexities of mental ill-health was deemed essential and education for all staff to promote person-centred care was very much part of the ward's ethos.

Summary of recommendations

Recommendation 1:
Managers should ensure individuals are offered regular one-to-one sessions with nursing staff and those sessions are documented within the individual's care records.

Recommendation 2:
Managers, including senior medical staff should ensure there is a consistent approach to the accurate recording of weekly MDT meetings on the template designed to capture all relevant information concerning an individual's progress in Ward 17.

Recommendation 3:
Managers must ensure there are systems in place to ensure all individuals are aware of their rights, and where restrictions have been put in place, this is clearly communicated to them, their named person and relatives, where appropriate.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk