Mental Welfare Commission for Scotland

Report on announced visit to: St John's Hospital, Mother and Baby Unit, Howden West Road, Livingston, EH54 6PP

Date of visit: 30 July 2024

Where we visited

The Mental Health Mother and Baby Unit (MBU) in Livingston is a regional inpatient service covering five NHS Health Board areas – Highland, Borders, Fife, Tayside and Lothian. NHS Forth Valley and NHS Grampian have a 'buy in' agreement when required.

The MBU provides specialist care for mothers and their babies delivered by a full multidisciplinary team (MDT); the majority of the admissions are post-natal mothers with babies who are up to one year old. This means that women can receive appropriate care and treatment for their mental illness, whilst being able to maintain and develop their parenting role and relationship with their infant.

The unit can accommodate six mothers and their babies at any one time. On the day of the visit, the unit had five post-natal mothers, six babies and one pregnant mother.

We last visited this service in August 2022 and made a recommendation in relation to the temperature in the ward.

On the day of this visit we wanted to follow up on the previous recommendation as well as look at the care and treatment being provided on the ward.

Who we met with

We met with, and reviewed the care of five people, four who we met with in person and five who we reviewed the care records of. We also met with one relative and spoke with one father.

We spoke with the clinical nurse manager (CNM), perinatal nurse consultant, consultant psychiatrist, charge nurse (CN), staff nurses, nursery nurses and the music therapist.

Commission visitors

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

Comments from individuals

The individuals we spoke with on the day of the visit provided extremely positive feedback about their care and treatment in MBU. Feedback included, "staff are wonderful, they are kind, caring and take the time to listen to me". One individual reported "I don't want to leave as my time here has been fantastic and so beneficial". Another individual told us that they "felt believed" by staff when describing symptoms which had supported their recovery. Some individuals told us that staff took the time to discuss how they were feeling and offered regular reassurance that they would recover, which supported them to "build confidence, self-esteem and self-belief".

Many of the individuals we spoke with told us that the input from the full MDT had provided them with opportunities to receive specialist skills-based interventions that supported and enhanced relationships and attachments with their baby and promoted improvement in their own mental health. Many of the individuals spoken with told us that they felt more confident in their role as a mother and felt the admission to MBU had been "extremely beneficial".

All individuals that we spoke with had fully participated in their own and their baby's care plan and felt involved in discussions and decision-making regarding their care and treatment. Most individuals were aware of discharge planning and commented that this was done at a pace that they and their family felt comfortable with. Many of the individuals commented on the "excellent links" the MBU had with community teams in the area they lived, which provided them with clear information on their support plan on discharge.

We heard from individuals that family members felt supported and welcomed by staff. Some individuals told us that contact with their other children was encouraged and gave examples of them attending the MBU at meal and bath times to promote relationships with their mother and sibling.

All the individuals we met with told us that they benefitted from meeting other mothers who were experiencing similar difficulties and valued the peer support available.

Comments from family

Family members we spoke with reported that they felt the care and treatment their loved one had received had been of a very high standard. One father said that his wife's care had been "absolutely brilliant" and commented on the specialist skill set and knowledge of the MDT providing the care and treatment to his loved ones. We heard that family members felt involved in decision-making and that their views were

listened to. We were told that communication with ward staff was “excellent” with regularly updated information being provided to fathers and family members.

We heard that staff were very supportive, welcoming, understanding and adopted a “non-judgmental” approach. We were told there was a “working as a team” culture in MBU, which included the family as part of the team.

We heard that families felt fully involved in discharge planning. One father told us that the discharge was being arranged at a “good pace” for all family members and took into account the needs of the family unit. We heard that this approach was supportive to families as it provided clear information on the support plan and who was responsible for providing supports.

One father told us that they had been offered input from the MDT to support them in their role as a father and husband which they found beneficial. We were told that information was provided on support groups for fathers and families to access if they wished.

Comments from staff

We heard that the MBU had not had a senior charge nurse in post for approximately seven months. We were told that the band 6 charge nurses and the senior management team had been supporting the nursing staff as a temporary measure. We were pleased to hear that the SCN post had now been filled.

We met with various members of the MDT during the visit. All staff spoken with told us that they enjoyed working in the MBU and felt supported to undertake their role. We heard that training and skill development was promoted and encouraged to support staff to enhance and maintain the specialist skill set, and knowledge required to work in MBU.

We were told that some more experienced nursing staff had recently moved on from the MBU, leaving some vacancies in the nursing team. We heard that five newly qualified band 5 staff nurses were joining the team in September 2024. While newly qualified staff were welcomed into the MDT, there was some concern in relation to the balance of experience, specialist knowledge and skill mix. However, we heard and saw that there were experienced charge nurses and nursery nurses in the MBU who would provide support to newly qualified staff joining the team. We were pleased to hear that that the charge nurses would be providing an induction programme to all new staff.

Care, treatment, support and participation

Nursing care plans are a tool which identify detailed plans of nursing care; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

We reviewed all care plans and found these to be of a high standard. Each individual had several care plans in place that were holistic and covered a range of needs identified from risk and functional assessments. The purpose of the admission was clear, and the care plans included robust information on the nursing interventions required to meet the care goals. We saw that comprehensive MDT assessments had been completed on admission that provided historical and personal information on the individual and their baby. This information supported care plans to be individualised, strengths-based and person-centred. The care plans adopted a holistic approach from the MDT, which promoted an understanding of the individual and their baby, the circumstances prior to the admission and a focus on future planning.

All of the individuals spoken with were aware of their care plan and there was evidence of their and their family's participation in the care planning which promoted a person-centred and personalised approach to care and treatment.

We saw regular review of care plans that evidenced robust information including summative evaluation regarding the efficacy of targeted nursing intervention, as well as the individuals' progress. We noted that individuals had participated in their reviews. We were pleased to find that some of the individuals we met had made significant progress and were near to discharge.

We were pleased to find that discharge planning was discussed at MDT meetings from the time of admission. The discharge planning was comprehensive, person-centred and holistic, including involvement from the individual, their family and community services. We heard that this approach was very supportive to the individual and their family.

We reviewed the care plans of the five babies. We found the care plans to be individualised, focused on the needs of the baby with clear detail on the interventions required to meet the need. The care plans were reviewed regularly and adjusted to meet any new need or changes to the baby's care.

We saw that physical health care needs were being addressed and followed up appropriately by either a midwife or duty doctor.

We reviewed risk assessments and were pleased to see an improvement in the way in which information was recorded on TRAKCare. We highlighted in the previous report that we found the risk assessments difficult to navigate due to the large volume of information and that a summary of the identified risks would be useful.

We found the risk assessments reviewed to be of an excellent standard. The risk assessments contained clear and concise information on past and current risk. They recorded protective factors, stressors and a risk management plan that detailed how the risk should be managed and the interventions required. We saw regular reviews

of the risk assessments and changes made to the management plan to reflect either new or reduced risks.

Each individual had a pass plan that detailed agreed pass arrangements and interventions required to support passes. We heard and saw that pass plans were reviewed regularly and adapted to reflect progress or new risk. We saw that for individuals who were informal patients, they had consented to any restrictions to pass planning, for example escorted pass, and that these restrictions were discussed with individuals regularly.

Care records

The care records were recorded on a pre-populated template with headings relevant to the care and treatment of the individuals and babies in the MBU. On review of the care records, we were pleased with the level of comprehensive and individualised information recorded by all members of the MDT. The information recorded was person-centred, strengths based, outcome and goal focussed and included forward planning. It was evident from reading the care records how the mothers' and their babies had spent their day, what members of the MDT had had interventions with them and the outcome of interventions. The care records were of a very high quality. The canned text headings were used to their full potential which promoted a holistic and recovery-based approach to the care of individuals in the ward.

There was evidence of frequent one-to-one interactions between mothers and their baby with all members of the MDT. The individuals we met with told us that they met with their key nurse and other members of the MDT regularly. The one-to-one interactions reviewed were comprehensive, personalised and strengths based.

There were positive and regular examples of staff promoting rights-based care by having discussions with individuals regarding views on their care plan, future planning and discussing any issues.

We were pleased to find that the care records included regular communication with families and relevant professionals including community teams.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. The MDT comprised of a consultant psychiatrist, trainee psychiatrist, nursing staff, nursery nurses, occupational therapist (OT), music therapist, peer support worker, social worker, psychology, health visitor and parent infant therapist. We were pleased to see the addition of an OT, peer support worker and parent infant therapist to the MDT. It was evident from discussions with the individuals, family members and from our review of the care records, that the MDT offered specialist and holistic care and treatment to mothers and babies.

The MDT met weekly in the unit, although Microsoft Teams was also used to host the MDT, which ensured greater participation and involvement from external agencies. The mothers and their families were invited to attend the weekly meeting if they wished. Individuals were supported to complete an 'MDT feedback form' prior to the MDT meeting, outlining their views and any issues regarding their care and treatment that they wanted discussed at the meeting. The consultant psychiatrist met with the mothers after the MDT to discuss the outcome of the meeting and care planning for the week ahead.

We found detailed recording of the MDT discussion, decisions and personalised treatment plans for the mothers and babies. We were pleased to find active family participation in the MDT discussion and decision making. There was evidence of clear links between MDT discussions and care plan outcomes, as well as evidence that individuals were making progress and moving towards achieving the aims and goals of the admission. It was clear that everyone in the MDT was involved in the care of the mothers and babies and committed to adopting a holistic approach to care and treatment.

When mothers and their babies were moving towards discharge, we found evidence of linking in with community services and invitations to attend the MDT and discharge planning meetings.

We saw psychological formulations for some of the mothers and babies. We found the psychological formulations to be of a high standard and beneficial for the individual and staff, as they provided an understanding of presentation and behaviours while promoting a holistic model approach to care and treatment.

Use of mental health and incapacity legislation

On the day of the visit, two individuals 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 electronically stored on TRAKCare and easily located.

Part 16 (section 235 to 248) 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. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments and the authorisation of medications prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 certificate if the individual is consenting.

On cross-checking the electronic records for each patient, the RMO had completed a T3 certificate for the one individual who required it. The T3 certificate reviewed was up-to-date and recorded authorisation of treatment.

Medication was recorded on the hospital electronic prescribing and medication administration system (HePMA). T2 and T3 certificates authorising treatment were stored separately on TRAKCare. It is a common finding on our visits that navigating both electronic systems simultaneously can be a practical challenge for staff. This is potentially problematic, as it can reduce the ease of checking the correct legal authority is in place when prescribing or dispensing treatment for those who are detained. For this reason, we suggested during this visit that a paper copy of all T2 and T3 certificates be kept in the ward dispensary, so that nursing and medical staff have easy access to, and an opportunity to review, all T2 and T3 certificates.

Any patient 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 patient had nominated a named person, we found this stored on TRAKCare.

Rights and restrictions

The MBU continued to operate a locked door on entry. The entry/exit was facilitated via a buzzer system and a door closing mechanism. At the entrance of the ward, there was a security system to monitor visitors, which was commensurate with the level of risk identified for mothers and their babies.

The individuals we met with during our visit had a good understanding of their rights, their detained status under the Mental Health Act or as an informal patient. We were pleased to note from the files that we reviewed that there were discussions on rights and legal status taking place between individuals and various members of the MDT.

There was also evidence of legal representation, granting of curator ad litem where required and advocacy involvement to support individuals understand their legal status and exercise their rights. There was a range of information on rights located in the main area of the ward.

We saw from our review of the care records that many of the individuals who were in the ward were there on a voluntary basis, although had restrictions placed on elements of their care, for example, pass planning. All of the individuals spoken with were aware of the restrictions and had consented to them with one individual commenting, “it supports me to feel safe”. On reviewing the care records for these individuals, we saw that the restrictions were regularly reviewed and discussed with the individual. We were pleased to see that progress in reducing restrictions had been made for many of the individuals.

We were pleased to see that the MDT supported the importance of ensuring the rights of the babies were promoted. The use of the 'getting it right for every child' (GIRFEC) framework ensured a strengths and rights-based approach was adopted to the care and treatment of the babies in the MBU. The addition of the infant therapist to the MDT further enhanced a rights-based approach to both the mother and their baby. We saw positive examples of interventions provided by the parent infant therapist that focussed on the experience of the baby, while providing support to the mother to enable attachment and bonding.

We saw that for some babies, the Children's (Scotland) Act 1995 was being used to outline the legislative framework for Scotland's child protection system. We saw that where harm was identified, the MDT and particularly the social worker, were actively involved in liaising with children and families social work teams to support and promote the baby's safety and welfare.

When we are reviewing patients' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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 did not find copies of advance statements in the files we reviewed however, were pleased to hear following discussions with individuals that they were aware they could make an advance statement and that they had access to information on these available to them in the ward.

Advocacy was available and provided by the local mental health advocacy service. We were told that advocacy attended the ward on request and provided a good service to mothers who wish to engage with this service.

The Commission has developed *Rights in Mind*[1]. This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

Activity and occupation

We heard and found evidence of a broad range of activities that were available to mothers and the babies in, and at times, out with the ward. The activities available included baby massage, sensory groups, messy play, music therapy, mindfulness, podcasts, local walks, baking and crafting. The unit also provided psycho-education groups for mothers, health promotion and anxiety management groups.

Activities were provided by various members of the MDT, however the OT and music therapist were actively involved in creating groups and individualised activity care

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

plans for mothers and their babies. We met with the music therapist on the day of the visit and heard that interventions offered are bespoke to the needs of the mother and their baby. We heard that the music therapist met with the individual to discuss the goal of the session and had a period of reflection at the end of the session to inform future sessions.

We saw that there were groups run on a weekly basis for example, by the music therapist however, and heard that groups did not always take place given the level of clinical acuity of the individuals in the MBU. Instead, there was a focus on more individualised and person-centred activity.

On review of the care records, we were pleased to find clear links between the outcome of functional and psychological assessments that highlighted unmet need, and the interventions required by the MDT to support need and enable recovery. As well as psychological based interventions, we saw that important practical supports provided by nursery nurses were offered to the mothers' and their baby. We heard and saw that interventions from nursery nurse staff helped promote skill, knowledge and confidence to mothers in providing safe care to their baby whilst also supporting improved attachment and bonding.

The mothers we spoke with on the day of the visit were very positive and complimentary about the activities offered. Some individuals told us that they did not feel 'pressurised' to attend groups which they found supportive and preferred to have a personalised approach to activity in the ward.

We were told that the unit offered groups and support for fathers and siblings. We heard from a father that the groups offered were supportive, as well providing beneficial information on how they could support their partner and baby. Family therapy sessions were offered, and these could involve siblings.

The individuals we spoke with on the day of the visit told us of the importance of the peer support they got when in the ward. Some of the mothers continued contact with each other following discharge.

The physical environment

The MBU was located on the first floor of St John's Hospital. The unit was well maintained, brightly lit with some homely furnishings which created a comfortable environment for the mothers and babies. The walls had some artwork that gave a sense of a warm and welcoming environment.

The day area was used by mothers and babies as a main communal area and it also functioned as a dining area with a small kitchen and a TV lounge. The day room was bright, with sensory areas for mothers and their babies. We were pleased to see that the MBU had created an environment that balanced the need of having a clinical

space for providing necessary care and treatment alongside a therapeutic space for mothers and babies that supported recovered.

Five of the six bedrooms had en-suite facilities, and there was a bathroom immediately next door to the bedroom where there was no en-suite. The bedrooms were spacious and had room for a cot. There was a nursery with five cots and baby changing facilities. We were told that mothers were encouraged to have their babies sleep in their rooms with them, however nursery nurse staff were available to offer support throughout the night if required. We heard from mothers that the option to have support from nursery nurse staff at night was "invaluable" to promote rest and enable their recovery.

The nursing station was at the centre of the ward and immediately visible on entry. There were two bedrooms behind the nursing station for mothers who required increased level of support and supervision. On the day of the visit, there was good visibility of staff in all areas of the ward and at the nursing station.

We made a recommendation in the previous report in relation to the high temperature in the ward. We were pleased to hear that repair and maintenance work had been undertaken to help regulate the ward temperature.

The MBU had access to a garden area which was located on the ground floor. We did not view the garden on the day of the visit, however, we were advised that no changes had been made to the garden area since the previous visit.

We heard that the garden was used regularly by mothers as part of their care and treatment plan, especially to support contact with children and siblings. Not all mothers could access the garden, as time off the ward was dependent on assessment of risk. This could result in mothers not being able to easily access an outdoor space. Individuals spoken to on the day of the visit did not raise garden access as an issue. Nevertheless, ideally the garden space would be directly accessible from the ward to ensure equity of access and use for all individuals. However, this was not possible due to location of the ward. We heard and saw that staff supported use of the outdoor space as much and as safely as possible.

Any other comments

The feedback from all individuals and relatives spoken with in relation to their experience of care and treatment in the MBU was very positive. We saw evidence of high standards of care during the visit that endorsed this feedback. There was a clear commitment by the MDT to provide high quality, specialist and skilled care to mothers and their babies. We were pleased to see involvement from fathers and family members and evidence of a holistic approach being adopted to support recovery.

It was positive to hear that the MBU maintained accreditation with the Royal College of Psychiatrists, College Centre for Quality Improvement (CCQI). In order to maintain accreditation, the service had demonstrated an ongoing commitment to continue to provide good quality to care to patients.

Summary of recommendations

The Commission made no recommendations; therefore, no response is required. However, we would 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. We will contact the service in three months' time to gather feedback about this.

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 individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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

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