Mental Welfare Commission for Scotland

Report on unannounced visit to:
Tippethill House, Rosebery Wing, Armadale, West Lothian, EH48 3BQ

Date of visit: 31 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

Rosebery Wing is one of two wards based in Tippethill House, West Lothian. The ward provides care and treatment for females over the age of 65 years with an established diagnosis of dementia and related conditions. Individuals admitted to Rosebery Wing have typically had admissions to the local general hospital and have been assessed as having complex care needs.

Rosebery Wing has 10 beds; on the day of the visit there were nine females receiving care and treatment. On the day of our visit, we were given an update from senior managers about the service's intention to commence refurbishment of an inpatient facility based at Craigshill; the service has been considering whether several wards across the county would be better served in a dedicated unit that has generous space both indoors and outdoors. The refurbishment work will require considerable funding investment and at the time of our visit, this funding had not been confirmed. We have asked for an update from the service in relation to timescales and communication with people who use older adult services and their relatives.

We last visited this service in August 2024 and made four recommendations in relation to documentation of one-to-one interactions between the nursing team and individuals admitted to the ward, concerns about the possible inconsistent oversight from senior medical staff and the need for individuals to be regularly reviewed, for managers to ensure there was an audit process in place for prescribed medication and for a review of section 47 certificates that were completed for individuals who were assessed as lacking capacity.

We received a detailed action plan from the service with timescales to ensure all four recommendations progressed towards completion.

Who we met with

We met with two people and reviewed their care records; we reviewed three other sets of care records. We also spoke with two relatives.

We spoke with the service manager, the charge nurse, the chief nurse and various nursing staff throughout the day

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

We had the opportunity to meet with people receiving care in Rosebery Wing and to speak with their relatives. We were told by relatives they regarded the nursing team as ”very kind, caring and compassionate”. We also heard from the relatives about their own positive experiences and that communication was considered important to them and that they felt involved in care and treatment reviews, with their opinions being sought throughout their relative’s admission. The relatives were positive about the environment, the ward was well looked after and met the needs of their relative. Furthermore, relatives felt confident that care was always person-centred and that team knew their relative well.

Due to the progression of illness, individuals we met with on the day of the visit were unable to fully engage with Commission visitors. Nevertheless, we were able to sit with and observe individuals throughout the day. Individuals with a diagnosis of advanced dementia require a high level of staff support throughout the day; we could see the attention to detail for all aspects of their daily lives and individuals were content in the company of nursing staff.

Care, treatment, support, and participation

Individuals’ care records were held electronically in TRAKCare and we found the electronic records system easy to navigate. We were informed there had been a development in terms of care planning with an improved electronic template now in place.

While the new template is in its infancy, we could see there were areas of focus directly relevant to individuals, who by virtue of their diagnosis and cognitive impairment, required enhanced level of support. Furthermore, in relation to person-centred care planning, there was an option to print off a copy of the care plan template which invited active participation between individuals, their relatives and their keyworker.

Where care plans previously had provided options to consider the needs of individuals, as well as specific identified goals and agreed interventions, the new care plan extended the areas of focus to include carers and relatives’ engagement, psychological formulations and communication. There had also been an addition to consider legal aspects to care and treatment that ensured individuals were aware of their rights and which promoted rights-based care.

As this new format and template has 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 and to receive feedback from individuals, their relatives and the ward-based team.

Of the care plans we reviewed there was a degree of variation between them. We reviewed care plans that were exceptionally detailed and provided the reader with an opportunity to appreciate the complexities of an individual's presentation and their needs. However, this level of detail was not consistent in other care plans we reviewed.

We raised the variation we found with the senior leadership team on the day of the visit as we were aware having exemplar care plans currently in place would evidence there were some staff who had a good understanding of preparing person-centred care plans and for other staff, they may require additional support to achieve this.

Where stress and distress had been evident for individuals admitted to Rosebery Wing, we found care plans that would be considered person-centred and had input from relatives.

We were again pleased to see there continued to be a focus upon individuals' physical well-being. We were told by the team this was essential to identify discomfort or underlying physical problems that could often be the consequence for stress and distress presentation. The clinical team had taken a robust approach to investigating the physical well-being of individuals. This included ongoing assessment, speaking with relatives and timely referrals to allied health professionals (AHPs) including physiotherapy to assess mobility to reduce the risk of falls. Care plans were influenced by AHPs assessments, observations from the nursing team and the advanced nurse practitioner (ANP).

To ensure participation and supported decision making, nurses should be able to evidence how they have made efforts to do this. We recognised that for some individuals, being an active participant in their care planning may be difficult such was their cognitive decline. However, we saw evidence of how nurses in Rosebery Wing made efforts to ensure individuals were provided with opportunities to consider preference and choice. This was particularly evident in relation to choosing what to wear each day, activities and day to day routines rather than individuals having to fit into the ward's schedule.

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.

Care records

Care records were also held electronically on TRAKCare and included a range of assessments in relation to physical well-being and mental health. Throughout individuals' care records, we could see evidence of where staff had adapted their

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

care and treatment to meet individuals' assessed needs. Person-centred care was a focus for staff, although we would like to have seen greater detail of this in the daily continuation recordings.

With the benefit of a 'canned text' framework that invited nursing staff to consider a range of areas to focus upon, the documented details of an individuals' daily engagement with staff was limited. We would like to have seen where individuals had experienced therapeutic engagement with the ward-based team, detail of the interventions that had been achieved and where an individual had required enhanced support. A richness of the daily narrative would have allowed the reader an understanding of what had gone well for the individual and areas where they had felt the need for staff to be present with them or support for relatives.

During our last visit to Rosebery Wing, we made a recommendation in relation to staff documenting evidence of one-to-one contact and providing written detail of this interaction. Unfortunately, we were unable to find evidence of a consistent approach to documentation therefore will repeat this recommendation again and, urge managers to consider how they will support staff to document key information in an individual's care record to promote reliable record keeping.

Recommendation 1:
Managers should ensure continuation records are detailed and capture all relevant information, including one-to-one interactions between individuals and staff.

Multidisciplinary team (MDT)
When we undertake visits to wards that provide care and treatment for older adults who have attracted diagnosis of dementia and the progression of their illness requires a holistic model of care, we would expect a range of professionals to provide specialist input.

It is recognised that individuals who present with stress and distressed behaviours benefit from a psychological approach to manage behaviours that have the potential to challenge. Unfortunately, Rosebery Wing lacked regular input from psychology. We spoke with the ward-based team and were told that there was no current access to psychology. Senior nursing staff had received training for working with older adults who present with stress and distressed behaviours however, for healthcare support workers, this type of training had not been made available. The benefit of having all staff skilled and knowledgeable was recognised by the leadership team and having input from psychology would be considered essential to ensure individuals were provided with person-centred holistic model of care and treatment.

Recommendation 2:
Managers should consider psychology provision for Rosebery Wing and opportunities for bespoke training to ensure all staff feel skilled and knowledgeable to work with adults who may present with behaviours that challenge.

Individuals admitted to Rosebery Wing had a consultant psychiatrist overseeing their care, including their medical care, during their admission. There was also an ANP who provided input in relation to the physical health needs of individuals. We were informed of the intention to recruit into a specialist ANP post specifically to support individual's mental health and wellbeing needs.

We heard that senior nursing staff and the consultant psychiatrist met fortnightly to discuss all individuals. While we would expect this meeting to have a detailed documented record, this was not routinely available. We were aware NHS Lothian had developed a mental health structured ward round template. This template invites the MDT members to discuss a range of areas and is a valuable tool for capturing relevant information from the clinical team, individuals and their relatives.

Unfortunately, we could not see a consistent approach to completing a record from MDT meetings. This was concerning as we could not find evidence of discussions, a record of who was involved in making decisions around care and treatment, nor any outcomes. Moreover, we could not find evidence of ongoing discussions in relation to discharge planning.

There were three individuals who had been identified as delayed discharge from hospital-based care. While we were informed there were specific reasons for those delays, we could not locate evidence of regular discussions with families or social workers based with the local authority, to see where progress was being made or what the reasons were for ongoing delays. Again, we would have expected this information to be included in the ward round template, which it was not.

Furthermore, we could not locate evidence of regular consultant psychiatry reviews that would inform the care team or AHPs of individuals' presentation or the progression of their illness. Following our last visit to the ward, consultant psychiatry provision had increased to Rosebery Wing, nevertheless, without evidence of regular reviews or discussions it was difficult to determine whether this increase had the intended positive outcome.

Following our last visit to Rosebery Wing were made a recommendation in relation to consultant psychiatry input. We are required to make a similar recommendation following this recent visit. The lack of documented evidence of regular senior medical reviews was apparent and equally, the lack of detailed MDT discussions and thorough record keeping was a concern.

Recommendation 3:
Managers must ensure medical staff undertake regular reviews of all individuals receiving care and treatment in Rosebery Wing and those reviews are documented in individuals' electronic care records.

Recommendation 4:
Managers including senior medical staff should ensure that MDT weekly meetings are recorded accurately on the template designed to capture all relevant information concerning an individual's progress in Rosebery Wing.

Use of mental health and incapacity legislation

At the time of the visit to Rosebery Wing there were no individuals subject to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

We reviewed all nine individuals who had section 47 certificates in place. Each certificate had been completed appropriately and had an accompanying treatment plan. All documentation relating to the AWI Act, including certificates around capacity to consent to treatment were accessible in paper copy and in electronic record system.

For individuals who had covert medication in place, not all appropriate documentation was in order, as most had no recording of reviews or the pathway where covert medication was considered appropriate. Each individual who had a covert pathway document in place also had guidance of when the pathway would be reviewed, this was typically during ward rounds.

When we looked for evidence of reviews to determine whether covert medication was necessary or could be discontinued, we could not locate any reviews or evidence of discussions between the clinical team. We had made a recommendation following our last visit around the need for improved practice around covert medication, so were disappointed to see little improvement, and are repeating the recommendation.

The Commission has produced good practice guidance on the use of covert medication.[2]

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

Recommendation 5:
Managers and medical staff must ensure the need for medication to be administered covertly is regularly reviewed and there is an audit process put in place to monitor this.

Rights and restrictions

Rosebery Wing continued to operate a locked door, commensurate with the level of risk for those in the ward. There was a locked door policy in place to support this. We were told EARS independent advocacy service offered support and engagement with individuals admitted to the ward, with additional support for relatives provided by 'Carers of West Lothian'.

We enquired how staff provide support 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 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 hospital admission should expect that their rights are 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 who will have legal safeguards in place. For individuals not subject to a legal framework and who would be viewed as receiving their care provided voluntarily, 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. We appreciated that for several individuals who had significant cognitive impairment, they may have little understanding of information provided to them. Nevertheless, we advised the ward-based team to consider arranging for accessible or easy read information to be given to individuals admitted to the ward and to their relatives too.

The Commission has developed *Rights in Mind.*[3] 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 the activities co-ordinator continued to provide input for all individuals and their input was highly valued. However, this provision had been unavailable for a period and had been missed. The team were looking forward to this

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

soon being available again. We were informed that occupation therapy (OT) provided recreational and therapeutic engagement, which was also valued, but sessions were limited. We were told that it was unlikely that additional OT resource would be provided to the ward.

The ward also benefitted from a range of volunteers from the local community. These included visits from a 'therapet', arts and music, and volunteers who visited the ward to spend time in the company of individuals while offering informal friendship. During our visit, we observed the nursing team taking time to engage with individuals. There was a recognition that overstimulation could cause individuals to feel anxious therefore, staff were calm and content to engage with individuals either on a one-to-one basis or in small groups.

There is a recognition that activities play an important role in ensuring individuals have opportunities for recreational and therapeutic engagement to promote well-being for people who present with episodes of stress and distress. We would liked to have seen evidence in the care records that provided an overview of which activities had taken place and the outcome of an individual's engagement. We brought this to the attention of the ward-based team on the day of the visit.

The physical environment

The layout of the ward consisted of 10 single bedrooms with en-suite facilities. The ward had made efforts to ensure the layout and bedrooms were considered 'dementia friendly' and accessible for people with cognitive impairment and limited mobility. The ward was bright and welcoming for individuals, visitors and staff.

The ward had several communal areas, including a bespoke café area for individuals and their visitors. The ward also benefitted from an accessible well-maintained garden. We could see the ward-based team were keen to ensure the ward was a welcoming space for everyone and the domestic team worked tirelessly to provide a ward that was clean and tidy.

Any other comments

The visit to Rosebery Ward was unannounced. This provided an opportunity to observe staff during their day-to-day engagement with individuals and their families. We observed positive interactions that were caring and compassionate. In caring for individuals who by virtue of their illness and its symptoms, can display behaviours that could be considered challenging, we were pleased to see these being managed with a calmness from a skilled team. We look forward to our next visit to Rosebery Wing.

Summary of recommendations

Recommendation 1:
Managers should ensure continuation records are detailed and capture all relevant information, including one-to-one interactions between individuals and staff.

Recommendation 2:
Managers should consider psychology provision for Rosebery Wing and opportunities for bespoke training to ensure all staff feel skilled and knowledgeable to work with adults who may present with behaviours that challenge.

Recommendation 3:
Managers must ensure medical staff undertake regular reviews of all individuals receiving care and treatment in Rosebery Wing and those reviews are documented in individual's electronic care records.

Recommendation 4:
Managers including senior medical staff should ensure that MDT weekly meetings are recorded accurately on the template designed to capture all relevant information concerning an individual's progress in Rosebery Wing.

Recommendation 5:
Managers and medical staff must ensure the need for medication to be administered covertly is regularly reviewed and there is an audit process put in place to monitor this.

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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