Mental Welfare Commission for Scotland

Report on unannounced visit to:
Camus Tigh, Kirkhill Road, Broxburn, EH52 6HT

Date of visit: 2 June 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

Camus Tigh is a six-bedded assessment and treatment unit for individuals with a primary diagnosis of learning disability, and who have complex care needs. The unit, located in a local community in West Lothian, is part of NHS Lothian's learning disability service. The aims and objectives of this service are to provide intensive therapeutic interventions that would help individuals to overcome the symptoms of their illness and return, as soon as possible and with support, to a less restrictive community environment.

On the day of the visit, there were three people in the unit. Two of the individuals had lived in the unit for many years and one individual had been admitted for a short period of further assessment and treatment following challenges in their community placement. We were told that two individuals' discharge was delayed due to lack of appropriate accommodation and social care services to meet the individuals' complex care, treatment and support needs.

We were pleased to hear that since the last Commission visit in June 2023, three individuals had been discharged into community placements.

We heard that the service was under organisational review, with the plan to discharge the remaining individuals and to close Camus Tigh. These plans had understandably caused a level of uncertainty and anxiety for individuals, their relatives/carers and the staff group.

On our last visit to this service, we made a recommendation in relation the service reviewing the psychology provision in the unit. On the day of this visit we wanted to follow up on the previous recommendation, as well as meet with people and look at the care and treatment being provided on the unit.

Who we met with

We met with one person and reviewed the care of all three people on the unit. We also spoke with two relatives.

We spoke with the clinical nurse manager (CNM), senior charge nurse (SCN), charge nurse and nursing staff.

Commission visitors

Kathleen Liddell, social work officer

Susan Tait, nursing officer

What people told us and what we found

The individual we met with on the day of the visit reported positive feedback about their care, support and treatment in Camus Tigh. The feedback included comments such as “staff treat me with respect”, “I feel safe” and “I like the staff and see my doctor regularly”. We also heard that there was opportunity to engage in activities in the unit and that the food was good.

Although the Commission staff were unable to have detailed conversations with other individuals due to their communication difficulties, as a result of their severe/profound learning disability, we were able to observe kind and caring interactions between individuals and staff. We saw individuals responding positively to staff interactions and seeking staff out. It was evident that the staff knew the individuals well and had adopted a personalised approach to individuals, using a variety of different methods such as the use of signs and object signifiers to support communication.

We made contact with two relatives following the visit. We were told by both sets of relatives that they found the care in Camus Tigh to be “excellent”, “exemplar” and “wonderful”. We heard that relatives viewed staff as “supportive”, “extremely caring” and “like an extension of my family”. Relatives commented that the care provided in Camus Tigh was very skilled and that all staff had a good knowledge of their loved one’s care and support needs. Relatives told us that their loved one had “complex needs and challenging behaviour” and the skilled and consistent care provided by Camus Tigh staff benefitted them.

We heard that relatives felt involved in discussions and decisions regarding their loved one’s care, treatment and support. Relatives told us that the communication from staff was very good and that they were kept “well informed”. We heard that in particular, the consultant psychiatrist and SCN consulted families and listened to and respected their views.

The relatives told us that they were concerned about the future of their loved one after being advised that Camus Tigh was closing. We heard anxieties in relation to the individuals not being provided with specialist nursing care in a community placement and the negative impact this would have on their loved one. One relative stated that staff had known their loved one for over 20 years and “knew exactly” the care and support they needed.

Both relatives we spoke with were also welfare guardians. We heard that they felt supported by the mental health officers (MHOs) in West Lothian social work department to continue to undertake their role as welfare guardian.

We heard that there had been a change in staffing since the last visit and that the unit had experienced staff leaving post, which resulted in periods of the unit being

short staffed. We were told that staff from the other learning disability wards in the Royal Edinburgh Hospital (REH) supported the unit during periods of short staffing however, there had been an increase in the use of bank staff.

We were told that organisational changes and the decision to close Camus Tigh had negatively impacted on staff morale. We heard that in order to support staff; the senior management team were providing regular updates and that human resources (HR) were available to offer support to staff where needed.

The staff spoken with during the visit had made a choice to stay at Camus Tigh as they wanted to support discharge of the remaining individuals into community placements. It was clear from speaking with staff that they were committed to offering high levels of care and treatment to the individuals in Camus Tigh.

Care, treatment, support, and participation

Care plans

We were informed that NHS Lothian had implemented a new person-centred care plan in April 2025. At the time of our visit, the service was in the process of transitioning existing care plans to the new system on TrakCare. We noted that while some information had been successfully transferred to TrakCare, other treatment plans and risk assessments remained stored on a shared drive and in paper files.

We found it challenging to navigate the various recording systems in use and were concerned that essential information may not be consistently accessible. Care plans should be easily accessible for all staff who need to reference them. Ensuring easy access to care plans is vital for delivering consistent, high-quality care, promoting coordinated support, and enabling a collaborative, multidisciplinary team (MDT) approach to achieving individuals' care and support goals effectively.

We discussed concerns over accessing information with the CNM, SCN and CN on the day of the visit, who recognised that the current system required urgent review. We heard that there was a plan in place to transfer the relevant information onto the new person-centred care plans on TrakCare imminently.

We saw that individuals in Camus Tigh had care and treatment plans to support admission goals, outcomes and identified plans of nursing care. We reviewed care plans stored on the shared drive and in paper files. We saw that the individuals in Camus Tigh had a wide range of complex mental and physical health needs. Individuals had multiple treatment plans and risk assessments to support all aspects of their care and treatment in the hospital and in the community. The information in these plans comprehensively detailed the care, treatment and support the individual required, providing a clear understanding to staff as to what nursing intervention was necessary to provide the support. We heard and saw that this level of detail was

fundamental in providing consistency and continuity of care for the individuals in Camus Tigh.

The information in the treatment plans was person-centred, strengths-based, with the individuals' likes and preferences reflected in the care plans. We found that the MDT were fully involved in the care and treatment plans, which supported a holistic approach to care. We saw that where appropriate, relatives/carers had input into care and treatment plans, providing information and their views.

We were able to review the new person-centred care plans on TrakCare and saw they had various headings for example, mental health, stress and distress, activities of daily living, legislation, physical health, risk and activity. We were pleased to see that the person-centred care plan had a 'what matters to me' section which promoted a personalised approach to support care and treatment. Although the care plans reviewed were not fully completed, the information reviewed provided detail on the care and support need, what interventions were required, was person-centred and evidenced participation of the individual and their relatives/carers.

Recommendation 1:
Managers should ensure that care plans are recorded in a central system that all staff can easily access to ensure coordinated support and a collaborative approach in achieving individuals' care and support goals effectively.

We were unable to find consistent or regular views of the care and treatment plans. We found that some of the care plans had not been reviewed in over a year and were particularly concerned that some of these care plans included the use of restrictive practices for example, continuous intervention and restraint. Although care plans were discussed and reviewed at the weekly MDT meeting, we were disappointed to find that these changes were not consistently reflected in the individual's current care plan.

The reviews that had been completed lacked comprehensive detail and did not provide a summative evaluation of the individual's progress. Many reviews recorded "no change," which made it difficult to determine whether the care plan remained relevant and effective for the individual.

We asked the SCN and CN how often reviews were completed in Camus Tigh and were told that the service aimed to review care plans six monthly. We were told that some reviews were delayed due to the new care plans being implemented however, there was recognition that comprehensive review of all care and treatment plans was required, to regularly assess if the targeted nursing intervention remained relevant.

Recommendation 2:
Managers should ensure care plan reviews are meaningful, include the effectiveness of interventions and reflect any changes in the individuals care needs.

The risk assessments we reviewed were of a high standard. The individuals had various risks assessments that supported them in the unit and in the community. The level of detail in the risk assessments was robust and included identified risks, a detailed risk management plan and a safety plan. This level of detail supported all staff working with the individual to have a good awareness of the support they needed to provide to ensure the individuals and others safety.

We saw that physical health care needs were being addressed and followed up appropriately. We were pleased to hear that the unit had a good working relationship with the local GP practice, with the GP and RMO jointly completing annual health checks for everyone. We noted onward referrals to relevant services, where appropriate.

All individuals were subject to the care planning approach (CPA). CPA is a framework used to plan and co-ordinate mental health and / or learning disability care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre. We found this paperwork to be of a high standard and regularly reviewed.

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
Information on individuals' care and treatment was held electronically on TrakCare. We found this easy to navigate. The care records were recorded on a pre-populated template with headings relevant to the care and treatment of the individuals in Camus Tigh.

We reviewed the care records of all individuals and found them to be of high quality, evidencing person-centred and individualised information. The care records detailed what activities the individual had engaged in that day and what had been positive or challenging for them. The information focused on the strengths of the individuals, encouraged skill development and independence. There was evidence of frequent one-to-one interactions between individuals, nursing staff and their consultant psychiatrist. We were pleased to find that the care notes included regular communication with families and relevant professionals.

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

We found good examples of discharge planning that evidenced the involvement of the individuals, welfare guardians and where appropriate, relatives. We heard and saw that the discharge co-ordinator was actively involved with individuals where discharge planning was in progress. We saw that regular meetings were taking place with the MDT and contact with relatives/carers to discuss discharge planning.

We were pleased to hear that there were regular Health and Social Care Partnership (HSCP) meetings to discuss and support discharge planning as well as attendance at the dynamic support register group to identify and support individuals who were at risk of unnecessary hospital admissions.

Multidisciplinary team (MDT)

The unit had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was one consultant psychiatrist and an activities co-ordinator. The unit also had two housekeepers who were responsible for domestic tasks and cooking on site. The unit had access to community occupational therapy (OT), speech and language therapy, a dietician and a discharge co-ordinator. Social work and MHOs were part of the wider MDT team.

In our previous report, we recommended improving psychology provision in Camus Tigh. While a dedicated psychologist had not been added to the MDT, we were informed and saw from review of the care records that access to psychological support had improved, along with noticeable progress in implementing a positive behaviour support (PBS) approach for all individuals at Camus Tigh. PBS is a person-centred framework for providing long term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge.

The MDT met weekly in the unit. We found detailed recordings of the MDT meeting, discussing all aspects of the individuals care and treatment plans and risk assessments, including legal status and any restrictive practice. 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 the MDT was fully involved in the care of individuals in Camus Tigh and committed to adopting a holistic and strengths-based approach to care and treatment.

Use of mental health and incapacity legislation

On the day of the visit, all three 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 and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment were stored on TrakCare and easy to locate.

Section 76 (1) of the Mental Health Act, states that where a compulsory treatment order has been made in respect of an individual, the individual's responsible medical officer should prepare a care plan relating to the person and include it in their medical records. We were pleased to find that all individuals had a copy of a s76 care plan. The s76 care plans were comprehensive, person-centred and evidenced consultation with relatives/cares and welfare proxies appointed under the AWI Act.

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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required. We reviewed the three T3 certificates and found that all medication prescribed was legally authorised and corresponded with the T3 certificate.

All individuals were subject to welfare and/or financial guardianship under the AWI Act. We found all documentation in relation to details of welfare proxies and the powers granted in the welfare and/or financial guardianships recorded on TrakCare.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 found all individuals had a section 47 certificate in place, with a comprehensive accompanying treatment plan.

Rights and restrictions

Camus Tigh continued to operate a locked door, commensurate with the level of risk identified with those on the unit.

The individual we met with during our visit had some understanding of their rights. We were encouraged to hear from the individual that they had regular contact with advocacy services. We were pleased to see that all individuals in Camus Tigh had a curator ad litem appointed to safeguard their interests in proceedings before the Mental Health Tribunal for Scotland.

On the day of our visit, one individual was subject to continuous intervention (CI). We were unable to locate an updated care plan for the CI, although were able to see that the MDT discussed the CI intervention weekly at the MDT meeting. From review of the documentation recorded on CI and from discussions with staff, we were

satisfied that CI was proportionate to the assessed risk and need. However, we were concerned that there was no formalised care plan to ensure the consistent provision of the CI. We discussed this matter with the SCN on the day of the visit and were given assurances that a CI care plan would be completed urgently.

Camus Tigh had a seclusion room and seclusion procedures. We heard that the seclusion room had not been used in over two years and instead therapeutic and continuous interventions were being used to manage periods of stress and distress.

We were pleased to hear that the level of restraint in Camus Tigh had continued to reduce. Where an individual required interventions involving restraint, we found care plans that recorded robust information on necessity for the use of restraint. The care plans evidenced a PBS approach and implementing strategies to prevent and reduce stress and distress. We also found that some of these care plans had not been reviewed regularly. We highlighted this to the SCN on the day of the visit and were assured a review of all care plans would be completed.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is specified in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found that documentation was in place however, had not been updated to reflect the current restrictions. We raised this with the SCN on the day of the visit and reiterated the importance of reviewing this documentation urgently.

The Commission has produced good practice guidance on specified persons[2].

Recommendation 3:
Managers should ensure that all restrictions being placed on people are legally authorised and accurately reflected in the specified person paperwork.

Recommendations 4:
Managers should consider MDT training in the application and use of specified persons legislation.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. None of the individuals in Camus Tigh had completed an advance statement. It was evident from meeting individuals and reading their case records that they did not have the level of capacity required to

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

make a valid advance statement. The Commission's good practice guidance on advance statements is clear that the person making an advance statement, must have the 'capacity of properly intending' the wishes specified in it. We were encouraged that advance statements were discussed in the CPA process in collaboration with the MDT, welfare proxy decision makers and advocacy services.

Partners in Advocacy provided advocacy support to individuals in Camus Tigh. We saw that advocacy were supporting individuals during the CPA process and were involved in meetings that supported discharge planning.

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 heard and found evidence of a broad range of activities that were available for individuals in and out with the unit. Camus Tigh had a dedicated activities co-ordinator four days a week. The activities co-ordinator worked a pattern of weekdays and weekends to support activity and occupation throughout the week. We heard the role of the activity co-ordinator was to develop individual activity planners for individuals that included social, recreational and sensory activities.

We were pleased to find an activity care plan in everyone's file that included a weekly programme of activities related to the individual's preferences and interests. The individual we spoke with told us that they engaged in a wide range of activities that they enjoyed.

We were also pleased to note that the activities co-ordinator documented details of the activities undertaken and also the individual's engagement and response. Examples of activities included swimming, trampolining, visits to local garden centres and cafés, picnics in the park, and trips on the barge.

The unit further enhanced social engagement through weekend events such as social evenings organised by nursing staff. We also saw evidence of staff actively seeking to introduce new and varied opportunities for activity to individuals.

The physical environment

There were no changes to the environment since the last Commission visit. We were told that given the organisational changes that were taking place, the unit had not been decorated since the last visit however, any repairs that were required were responded to quickly by the estates department.

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

The environment was well maintained. The entrance to the ward was bright and the environment cleanliness was of a very high standard. There was artwork on the walls throughout, which promoted a sense of a warm and welcoming environment.

We were able to view all the individuals' bedrooms, and were pleased to see the level of personalisation, making their rooms as homely as possible. There were no en-suite facilities in Camus Tigh, although the bath, shower and toilet facilities were adequate.

There was a large and well-maintained garden area that individuals could access. The garden had a fence to ensure privacy. We were told that individuals used the garden area regularly in the warmer weather. The garden area was a pleasant, therapeutic and relaxing space for people to enjoy.

Any other comments

The feedback from the individual and relatives we spoke with about the care and treatment in Camus Tigh was extremely positive. We saw evidence of good care during the visit that supported this feedback. There was a clear commitment by the MDT to provide high quality, specialist and skilled care to individuals in Camus Tigh.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plans are recorded in a central system that all staff can easily access to ensure coordinated support and a collaborative approach in achieving individuals' care and support goals effectively.

Recommendation 2:
Managers should ensure care plan reviews are meaningful, include the effectiveness of interventions and reflect any changes in the individuals care needs.

Recommendation 3:
Managers should ensure that all restrictions being placed on people are legally authorised and accurately reflected in the specified person paperwork.

Recommendations 4:
Managers should consider MDT training in the application and use of specified persons legislation.

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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