Mental Welfare Commission for Scotland

Report on announced visit to:
Lochview Hospital, Stirling Road, Larbert, Falkirk, FK5 4AE

Date of visit: 18 March 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

Lochview Hospital in Falkirk specialises in assessment and care and treatment for men and women who experience learning disability, autism and complex needs.

This service is formed of three, six bedroomed houses accommodating up to 18 adults. Three of the bedrooms in house two remained closed due to them being configured as a bespoke suite for one individual who was in long term therapeutic seclusion. There is a fourth house, used as a multifunctional facility with offices and therapeutic space.

On the day of our visit, 12 of the beds were occupied with six individuals considered as being delayed discharges. Delayed discharge occurs when an individual is clinically ready, however, unable to leave hospital due to a lack of necessary care, support or accommodation available. We were told for these individuals; it was due to a lack of community placements. Most adults were receiving compulsory care and treatment, some of whom were from other health board areas.

We last visited the service in March 2024 and then again in July 2024. The latter was as part of a mini themed visit looking at how many individuals were in hospital longer than ten years. On the earlier visit we made a recommendation about the need for a local seclusion policy. The service completed this and provided us with a copy.

There had been some changes to the service since our last visit, including vacancies in the substantive senior charge nurse (SCN) and clinical nurse manager (CNM) posts. The SCN vacancy was being filled by an interim SCN, and a new service manager had also taken up post. There was active recruitment underway for registered nurse and health care support worker (HCSW) vacancies.

Lochview Hospital had been identified as a pilot site for the quality improvement initiative ‘safer together’ launched in 2024. This was a collaboration between NHS Forth Valley, Clackmannanshire and Stirling health and social care partnership (HSCP), Falkirk HSCP and the University of Stirling. The initiative aimed to improve patient safety across several areas through clinical policy review and coordination of improvement support. In addition to this, the service had recently submitted their application for accreditation with the Royal College of Psychiatrists (RCPsych). RCPsych offers accreditation programmes for inpatient mental health services to help improve the quality of care delivered. This is achieved by using a structured framework to assess against a set of core standards with the aim of overall quality improvement.

Who we met with

Four individuals had intimated that they would like to meet us however, one person changed their mind on the day. Despite only meeting three adults individually, we did

take the opportunity to visit each house and were able to see people in their environment participating in activities and interacting with others.

We reviewed the care records of seven people, one of whom we met in person. We were told that relatives had been informed of our planned visit, but on this occasion, no one had requested to meet us on the day or have contact with us later.

Prior to visiting we had an online meeting with the service manager, interim SCN and one of the deputy senior charge nurses (DSCNs). During the visit, we had opportunities to meet additional nursing team members, the consultant psychiatrist, specialist occupational therapist (OT), and an OT technical assistant.

Commission visitors

Denise McLellan, nursing officer

Sandra Rae, social work officer

Andrew Jarvie, engagement and participation officer (lived experience)

What people told us and what we found

People we spoke with told us they enjoyed spending time with staff and getting out of the unit into the garden and going for walks. One person told us “I like staff very much” and that they particularly enjoyed using the bikes, playing ‘I spy’ and walking around the local park. They told us that they had a nice bedroom which we found had been personalised and on observing them with staff, we saw that they enjoyed a warm and therapeutic relationship. They also said it was very important to them that they were given their favourite foods.

One other described staff as being “excellent.” They told us that they had made friends in hospital, but they would like to be living in their own home as they had been living in hospital “too long.” Accommodation and support had been allocated and the care provider visited twice weekly as part of the discharge process. They told us they were looking forward to moving to their new house soon.

Another individual who had recently been admitted said they did not want to be in hospital. They wanted to be at home and hoped it would not be a lengthy admission. They had recently moved from another house in the unit, due to an unsettled presentation and the need to manage ongoing risk. They said that they were happy about being moved to a different house because it made them feel safer and they liked their new room. They were happy that staff would make them food that they liked. This person had contact with their family who visited regularly. They also told us that they enjoyed when staff took them out of the hospital to see the swans nearby.

Care, treatment, support, and participation

We found evidence of positive communication and involvement of relatives and proxy decision makers regarding care and treatment decisions. We noted one recent example where the relatives were kept informed, regarding the decision to return an individual to hospital for a review of their medication and a subsequent move within the unit. Care plans included family contact as being important for individuals and carers were encouraged to provide input to identify meaningful activities and personalised care for individuals.

For one individual whose previous care environment was not suitable, adaptations had been made to their living environment to meet their specific needs. This customisation involved the adult being nursed in long term seclusion in their own designated area, with enhanced nursing support.

Detailed person-centred positive behavioural support (PBS) plans were in place to manage behaviours that challenged. The aim being to help understand the behaviours and focus on implementing strategies to improve an individual’s quality of life and reduce the need for restrictive practices.

Physical health monitoring was robust with the standard tools to monitor physical health screening available and completed in accordance with individual monitoring requirements. We could see involvement from a variety of professionals. The advanced nurse practitioner (ANP) attended the ward during the visit to review one individual who had injured their toe, and we saw that an optician also visited to provide eye care.

Psychology lead on formulation, which is a rationale or summary/narrative about the factors underpinning the development and maintenance of a problem being faced by an individual. They also undertook specialist, intensive psychological therapies, with mental health nurses who delivered lower intensity psychological interventions.

We could also see where enhanced nursing support to individuals would change in response to their needs; some individuals sometimes required support from three nurses, dependent on the situation.

We were told that whilst 50% of the individuals on the ward were delayed in their discharge, some progress had been made towards addressing this and where discharges had been delayed, we saw involvement with other agencies to progress this. One person had been allocated a new social worker and engagement was at an early stage with active involvement about the possibility of an out of area placement due to their bespoke needs. Monthly minuted meetings were taking place to explore availability of placements, expedite progress, and address issues which may be contributing to delays. We were told that social work had also increased their input.

Care records

Individual records were held on Care Partner, the electronic health record management system in place across NHS Forth Valley. A review of the electronic care records was undertaken. We were pleased to find that the standard of recording had been maintained. Care records were holistic, well written, extensive, informative, included multidisciplinary input from clinicians involved and gave a real sense of everyone, including an overview of their day and evening. Carers' views were evidenced throughout in the care records. Peoples' care needs correlated with their risk assessment and risk management plans clearly set out how these risks were being managed. There was evidence that multidisciplinary discussion had taken place in relation to this and risk assessments were updated regularly.

Care plans provide a written record that describes the care, treatment and interventions that a person should receive to ensure that they get the right care at the right time. Care plans are a crucial part of supporting and helping the recovery process. Individuals care plans were varied and covered aspects of physical and mental health needs. Overall, they were person-centred, written using friendly language, detailed and informative with evidence of regular review of outcomes. Talking mats and social stories had been used to maximise participation and the

language used was respectful. They were varied and the goals provided insight into the level of care and support needed. We were told that the SCN/DSCN undertook monthly auditing.

Information was not limited to the electronic notes, we also found relevant information in bedrooms, such as positive behaviour plans, making this readily available to everyone providing care and support to individuals. We saw visual aids and a communication board in one area being used to help increase an individual's understanding. We saw daily planners which were detailed and extensive and there were social stories available giving an overview of individuals' lives and risks.

Multidisciplinary team (MDT)
Consultant learning disability psychiatry input was provided by one psychiatrist across the three houses and there was additional allocation from a specialist trainee doctor (ST6). The nursing team was diverse with the inclusion of one registered adult nurse as well as mental health and learning disability nurses. Input from allied health professions (AHPs) comprised of the OT team, psychology, physiotherapy, dietetics, speech and language, podiatry and art and music therapy. Social workers and mental health officers (MHOs) were involved and attended meetings where appropriate. We also heard that where relevant, there was representation from the learning disability (LD) acute liaison nurse and the LD support team which included forensic and crisis services.

MDT meetings occurred weekly and were attended by the consultant psychiatrist, ST6, nursing from each of the houses, OT and other AHPs who were actively involved. It was easy to identify attendees, meeting discussion, outcomes and actions from the proforma used. It was a well-structured template guiding discussion to include aspects of care and treatment such as medication, legislation, rights and risk. We also noted that the local independent advocacy provider was involved in some meetings.

Use of mental health and incapacity legislation

On the day of the visit, 11 of the 12 individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Detention paperwork was available and current.

Section 76 (1) of the Mental Health Act requires the preparation of documented care plans for people who are subject to compulsory care and treatment. There are various points in the life of a compulsory treatment order (CTO) or compulsion order (CO) where there is a formal requirement for a care plan to be produced or amended. On reviewing the records, we saw evidence of section 76 care plans in the medical records that were comprehensive and evidenced consultation with family/carers and proxy decision makers.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in date and available in hard copy format as well as being on Care Partner. There were two individuals in house two who were prescribed medication which was not authorised by their current T3 certificates. We discussed this with the RMO and SCN and were told this would be rectified.

Recommendation 1:
Managers and medical staff should ensure that all prescribed psychotropic medication is legally authorised and that compliance with this is regularly audited.

When someone is unable to make decisions about their own welfare, a court can appoint someone to make decisions for them under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). This person is known as a welfare guardian and can be a partner, family member, friend or social worker. Copies of welfare guardianship orders and power of attorney certificates were available. We found that five people were being supported to manage their funds by the hospital in accordance with the AWI Act.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be provided. 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. Section 47 consent to treatment certificates were in place, current and had accompanying individualised treatment plans that had been discussed and agreed with welfare guardians. The treatment plans were detailed, and it was clear there has been communication. For one person we saw evidence of attempts to promote least restrictive practice by limiting physical interventions.

Rights and restrictions

The unit operated a locked door policy, and we were satisfied that this restriction was commensurate with the complex needs of individuals. We discussed with the SCN that providing an easy read version of the policy may be helpful for people living in this environment and it was agreed the MDT would consider this.

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 someone is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. This was relevant for one individual, and it was evident from reviewing their records that all necessary paperwork including a reasoned opinion, explaining why these restrictions were necessary had been completed.

Documentation also evidenced involvement from Forth Valley Advocacy service, and we saw where the MHO agreed to make a referral for someone recently admitted.

Activity and occupation

The service continued to provide a broad range of activity in accordance with individuals' preferences. Weekly activities onsite included art, baking, board games, karaoke, beauty treatments, bowling, bingo and DVD nights, as well as excursions in the community. Overall, we saw examples of comprehensive activity provision recorded in the activity care plans and how this was being supported by staff. There was good use of the enclosed garden area where outdoor gym exercises could be enjoyed along with walking outdoors. Efforts had been made to promote exercise in an inclusive way, and we saw participants' "Olympic Games" certificates displayed.

The physical environment

The service consisted of three houses for accommodation with the fourth being used as a multipurpose area for offices, clinics and the sensory 'snoezelen' room. The sensory room was a valuable asset, so we were disappointed to see it had been used to store some wheelchairs. We were told that storage was an issue generally and we had noticed laundry baskets stored inside a bath in one of the houses. We were informed that this matter was regularly raised in safety huddles.

The communal areas were warm, clean, safe and adapted well to individuals' needs. The décor appeared fresh and calming with decals applied to walls to brighten up and soften the clinical appearance. There was clear signage, and the decor was augmented by photographs of residents enjoying various activities with information attached describing this. These efforts helped to create an overall pleasant and welcoming ambience. There were photographs of nurses working in the house to help individuals identify them in their role.

Individual bedrooms were personalised, and we could see a clear focus on making them homely with care and attention to what was important to the person. Furnishings were non-clinical including free standing wardrobes and chests of drawers. We also saw equipment available to stimulate interest such as educational toys and other items of personal relevance. In one individual's bedroom we found detailed information gathered from the assessment process. This was attached to a white board and included helpful knowledge about the person, giving clear and detailed advice to guide staffs' approach to care and treatment in order to maximise the benefit for this person. It included information about likes and dislikes, as well as what was important to them and what helped when requiring staff intervention.

Each bedroom had ensuite toilet facilities, but showers and baths were located separately in the communal areas. In house one, we noted that the main bathroom was also being used to store items such as laundry baskets.

We were unable to visit inside the area being used as a seclusion suite in house two during the visit, as we were told this would cause significant distress to the individual. We had been able to see this on a previous visit when the individual was located elsewhere due to refurbishment work. We were given a description of the facilities and told that the suite of rooms was tailored to their needs with safety being paramount. The layout comprised of a sleeping area, activity and storage areas. There were ensuite facilities for personal use and unfettered access to a garden area for sole use. Staff would engage this individual for limited amounts of time depending on how much this could be tolerated, with an attempt to increase periods incrementally.

Due to the limited direct face-to-face interaction, a CCTV camera with heat detector was in operation to monitor the individual and the environment. The CCTV monitor was in the nursing office in the corridor, and we noted that the screen was visible through the office window. We had commented on this on a previous visit and were told that the camera images could be switched off when necessary. In order to maintain this individual's privacy and dignity we felt that that this should only be viewed by clinical staff from within the office. We had seen opaque frosting added to a window in house one and considered that using a similar covering could be one solution to address this issue. We will follow this matter up with managers.

Recommendation 2:
Managers should ensure that individuals' privacy and dignity is maintained at all times, in accordance with the Data Protection Act (2018).

Prior to the visit we had become aware of the use of bolts on the doors to this suite. We discussed this with some of the team during the visit and again at the feedback meeting at the end of the day. We were told the bolts were introduced to reinforce the doors due to necessity following extremely high levels of anxiety and challenging behaviour which included aggression and injuries to staff, but that they also served as a psychological safety measure for the individual. We suggested including this detail regarding the psychological aspect within the care plan. Given the custodial appearance we wondered whether there could be an alternative, such as a lock operated by keypad function. An explanation was given that the sound of the bolt being unfastened enabled the individual to prepare for the door being opened. This individual was able to tolerate staff for brief interventions, and it was felt this was a useful psychological tool to help prepare the individual to understand and anticipate change which helped reduce their anxiety and distress. We were told that the MDT continued to review this weekly to plan for progression.

Any other comments

We were encouraged to see the standard of care being delivered in Lochview Hospital and the cohesiveness of the team. We were also pleased to hear of their inclusion in the ‘safer together’ quality improvement project and of their ongoing ambition to achieve RCPsych accreditation and wish them best wishes in this worthwhile endeavour.

Summary of recommendations

Recommendation 1:
Managers and medical staff should ensure that all prescribed psychotropic medication is legally authorised and that compliance with this is regularly audited.

Recommendation 2:
Managers should ensure that individuals' privacy and dignity is maintained at all times in accordance with the Data Protection Act (2018).

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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