Mental Welfare Commission for Scotland

Report on unannounced visit to:
Maple Villa, Larch Grove, Livingston, EH54 5BU

Date of visit: 9 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

Maple Villa is a 14-bedded unit for men who have attracted a diagnosis of dementia and related conditions. The ward covers the West Lothian area of NHS Lothian.

We were provided with an update from senior managers on the day of the visit as there was an intention to commence refurbishment of Maple Villa and the adjoining ward which had closed the previous year. There had been a recognition that having several wards across the county would be better served in a unit that had generous space both indoors and outdoors. The refurbishment work will require considerable funding investment and at the time of this recent visit to Maple Villa, 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.

On the day of the visit to Maple Villa the ward was full; this is typical of the ward's capacity however, we were informed that with regular patient pathway meetings to promote timely reviews and referrals to care homes, the ward has seen an improvement to admission and discharge pathways.

We last visited the service in June 2024 and made four recommendations in relation to recording of one-to-one discussions between nursing staff and individuals. We also made two recommendations in relation to prescribed medication for individuals who were subject to Mental Health (Care and Treatment) (Scotland) Act 2003. We advised regular audits to ensure prescribed medication was authorised and recorded correctly. Lastly, our fourth recommendation related to communication between services and to ensure all relevant information gleaned prior to admission is documented within an individual's pre-admission record. We received a detailed action plan and updates from the service.

Who we met with

We met with, and reviewed the care of six people, six who we met with in person and five who we reviewed the care notes of. We also met with two relatives.

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

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Denise McLellan, nursing officer

What people told us and what we found

We had the opportunity to meet with people receiving care in Maple Villa and their relatives. We were told by people they regarded the nursing team as “lovely and very kind”, “nurses always make time for you”.

We heard from relatives about their own positive experiences, where communication was considered important and relatives felt very involved in care and treatment reviews, with their opinions sought throughout their relative’s admission. Relatives were positive about the ward’s medical staff; “they are lovely” and “always available to listen to me”. Furthermore, relatives felt confident that care was always person-centred and that team knew their relative well.

The visit to Maple Villa was unannounced. This provided an opportunity to consider day to day activity on the ward and how nursing staff undertake their duties and responsibilities. We saw interactions between staff and individuals that were warm and compassionate. While several individuals required to be supported and cared for in their bedrooms, the team ensured people were provided with opportunities to spend time with them to reduce the risk of social isolation.

Nursing staff were present throughout all communal areas of the ward and positively encouraged relatives to participate in mealtimes and social engagement. We were told by relatives that continuing to provide a degree of care for their own relative was important to them and they valued the opportunities to support mealtimes and one-to-one activities.

Care, treatment, support, and participation

Individual’s care records were held electronically in TrakCare, which we found 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 was 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 the previous care plans had provided options to consider the needs of individuals, specific identified goals and agreed interventions, the new care plan had extended the areas of focus to include, for example, carers and relatives’ engagement, psychological formulations and communication. Furthermore, there had been an addition to consider legal aspects to care and treatment to ensure individuals were aware of their rights and to promote rights-based care. As previously stated, this new format and template had only been in place for a short period, therefore we are looking forward to reviewing care plans

during our next visit to see how person-centred care has been developed further and to receive feedback from individuals, their relatives and the ward-based team.

Care records
Care records included a wide range of assessments including functional assessments undertaken by allied health professionals (AHPs), risk assessments, and specific care plans to support individuals who presented with stress and distress associated with their dementia diagnosis.

We were pleased to see input from psychology and there was a recognition working with individuals who presented with behaviours that had the potential to challenge required a psychological approach to understanding their distress.

Throughout individuals care records we could see evidence of where staff had adapted their 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 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 individual's daily engagement with staff was limited. We would like to have seen where individuals had experienced therapeutic engagement with the ward-based team, 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.

Recommendation 1:
Managers should ensure continuation notes are detailed and capture all relevant information relating to an individual's care, treatment and presentation.

We were pleased to have found physical health care was deemed a priority for individuals admitted to Maple Villa. The team recognised individuals living with dementia and significant cognitive impairment were by and large unable to verbally express their pain or discomfort.

We were told by relatives that the nursing and medical team were very attentive and intuitive to understanding each individual and their presentations that may indicate when an individual was experiencing discomfort and managed this promptly and appropriately. Physical care and monitoring was undertaken regularly and any referral that required specialist medical attention was made without delay. While the ward benefitted from weekly input from a local general practitioner (GP), their input with people they saw was not evidenced in the individual's electronic care record. We were informed the GP service was highly valued however, as the GP did not have access to TrakCare, timely notes were not available. This was a source of frustration

for the ward-based team, and we highlighted this as a possible issue in terms of communication, risk management and follow-up from referrals to specialist services.

Recommendation 2:
Managers should consider how to support visiting general practitioners (GPs) to access TrakCare to ensure all GP reviews are recorded and accessible for the ward-based team.

Multidisciplinary team (MDT)
On the day of the visit to Maple Villa we were keen to hear which AHPs were available to provide assessments and specific input aligned to their professional expertise.

We heard that occupational therapy (OT) was provided for two hours per week. Access to physiotherapy, speech and language therapy and dietetics was via referral. We were told referrals were accepted and actioned without issue. The ward-based team, while appreciative of the input provided by AHPs, would have preferred substantive positions for the ward. In particular, access to daily OT was considered essential as their expertise was particularly valued by the service.

Furthermore, we were told the ward would benefit from regular input from psychology to undertake psychological formulations which were recognised as an important part of the model of care for people with dementia and related conditions. Psychological formulations provide an understanding of why individuals may experience stress and distress which can be present for people with dementia. Furthermore, formulations provide opportunities for the ward-based team to invite relatives to be active partners in care planning and understand what is and was important to the individual and their family. At the time of the visit while there was not regular psychology input into the ward however, a psychologist provided training for nursing staff in relation to supporting individuals who present with stress and distressed behaviours.

Medical input was provided by a consultant psychiatrist and visiting GP. We would expect to locate a detailed record of MDT meetings, including a record of attendance, discussions, outcomes and any actions required. We would also have expected to find discussions in relation to discharge planning and progress in terms of allocation of care home placements. We were told the ward had benefitted from having weekly ‘patient flow’ meetings with West Lothian older adult services. Having the addition of a social worker to those meetings had provided timely information and updates to all services however, discharges from hospital-based care was an issue, in part due to limited appropriate community or care home placements.

We reviewed the MDT meeting records and found those to be lacking in detail particularly in relation to current care and treatment and future planning. We were

aware NHS Lothian had developed a mental health structured ward round template. This template invited the MDT members to discuss a range of areas and was a valuable tool for capturing relevant information from the team including individuals and their relatives. Unfortunately, we could not see a consistent approach to completing a record from MDT meetings, which was concerning as we could not find evidence of discussions, who was involved in those and any outcomes.

Recommendation 3:
Managers including senior medical staff must ensure that weekly MDT meetings are recorded accurately on the template designed to capture all relevant information concerning an individual's progress in Maple Villa and include a record of attendance, discussions, outcomes and actions.

Use of mental health and incapacity legislation

On the day of the visit, six 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 Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act) was available on TrakCare.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

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 (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 were pleased to have found significant improvements from our last visit to Maple Villa. The ward-based team had ensured all documentation relating to the Mental Health Act and AWI Act were in place and proxy decision makers were regularly consulted as part of care and treatment for individuals admitted to Maple Villa.

For people who had covert medication in place, all appropriate documentation was in order, with evidence of reviews where necessary and discussions held with relatives and proxy decision makers.

The Commission has produced good practice guidance on the use of covert medication.[1]

Rights and restrictions

Maple Villa 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 provided 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 an admission should expect their rights to be at the forefront of any decisions and discussions.

For some people this may mean they are subject to detention under the Mental Health Act and will have legal safeguards in place. For individuals not subject to a legal framework and are receiving their care 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 for several individuals who had significant cognitive impairments 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 their relatives too.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

Since our last visit to Maple Villa the activities co-ordinator had left their post however, a newly appointed co-ordinator was due to start in the coming weeks. This post was highly valued by the ward-based team and individuals admitted to the ward. The recognition that activities played an important role in ensuring individuals had opportunities for recreational and therapeutic engagement, promoted well-being for people who present with episodes of stress and distress.

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[1] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492
[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

The ward on the day of the visit was calm, with nursing staff undertaking small group and individual engagement opportunities. We saw several relatives also in the ward who were made to feel welcome in supporting their relative with a range of activities and supported during mealtimes.

We were told having volunteers visiting the ward was essential, particularly the regular visits from a therapet and local singer. For some people we spoke with, there was a sense of little to do during the day. We informed the ward-based team of this view and asked whether the new activity coordinator could possibly canvas individuals to determine what activities would be interesting for people admitted to the ward and whether there could be a range of one-to-one activities offered, alongside group activities.

The physical environment

The layout of the ward consisted of 14 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. We were told there were several areas in the ward that required repairs and investment however, with the possibility of service reprovision in the future there was a sense repair work was not always seen as a priority. We advised the leadership team while plans were in place to consider service redesign it remained necessary that current inpatient wards were to receive investment and any repairs or maintenance required to be undertaken.

The ward had several communal areas, and this included a bespoke café, cinema and barbers' shop. Furthermore, 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

Maple Villa admitted individuals who by virtue of their diagnosis and significant cognitive impairment required hospital-based care. We heard from relatives how they valued the compassionate person-centred care their family member had received. While it was clear there were occasions when staff experienced many competing demands, their commitment to provide care that was bespoke to the needs of individuals was unwavering. We look forward to our next visits to Maple Villa and hear how future plans have progressed.

Summary of recommendations

Recommendation 1:
Managers should ensure continuation notes are detailed and capture all relevant information relating to an individual's care, treatment and presentation.

Recommendation 2:
Managers should consider how to support visiting general practitioners (GPs) to access TrakCare to ensure all GP reviews are recorded and accessible for the ward-based team.

Recommendation 3:
Managers including senior medical staff must ensure that weekly MDT meetings are recorded accurately on the template designed to capture all relevant information concerning an individual's progress in Maple Villa and include a record of attendance, discussions, outcomes and actions.

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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