

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Loch View Hospital, Houses 1 to 3, Stirling Road, Larbert,
Falkirk, FK5 4AE

Date of visit: 25 May 2026

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

Loch View Hospital specialises in assessment and care and treatment for adults who experience learning disability, autism and complex needs. It comprises of three, six bedroomed houses accommodating up to 18 adults. On the day of our visit there were 11 individuals, 10 of whom were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

All houses were mixed-gender. House 1 had four individuals one of whom was accommodated in a 'pod' to separate them from the others in line with their risk management plan. We were told they could access the communal lounge under supervision. Three of the bedrooms in House 2 remained closed due to them being configured as a bespoke suite for one individual who was in long term therapeutic seclusion to manage risk and their level of distress. We saw a person-centred approach to their care and social work had become more involved to source alternative accommodation. House 3 accommodated four people.

We last visited the service in March 2025 on an announced basis. We made two recommendations and the service responded to these. We had noted that there was a risk of non-clinical staff being able to view images of an individual being remotely monitored, a film coating was immediately applied to obscure this window. In conjunction with the other in-patient services, a short life working group was established to ensure psychotropic medication was appropriately authorised and regularly audited.

As well as following up on our previous recommendations, we also wanted to give individuals and their relatives an opportunity to speak with us regarding their care and treatment, and to ensure this was being provided in line with a human rights' framework.

Who we met with

We met with and reviewed the care of five people and reviewed the care records of a further two people. We met with nursing staff, the senior charge nurse (SCN), clinical nurse manager (CNM) and consultant psychiatrist. We also spoke with two relatives by telephone call. The lead nurse, clinical director, interim head of service, director of nursing and service manager attended the feedback meeting at the end of the visit.

Commission visitors

Denise McLellan, nursing officer

Kathleen Liddell, social work officer

Susan Tait, nursing officer

What people told us and what we found

Overall, the feedback we received was positive from those we spoke to except for one person who did not agree that they should be in this hospital and was unhappy about their treatment. They felt they should be given more information as they found the 'easy read', version lacked detail. Others told us they liked their rooms and the staff.

One relative told us that nursing staff were good at spending time with their relative, looking after them and understanding their needs. They were less happy with the multidisciplinary team (MDT) and considered that treatment had been more responsive and intuitive with previous clinical staff. They felt approaches to finding suitable accommodation was like "trying to place a round peg into a square hole" and that minimal progress had been made over the years. In respect of communication, although they were given opportunity to offer their views, they felt suggestions were not acted on with risk level consistently dictating a lack of access to community opportunities.

Another relative said of the staff; "I can't praise them enough. Over two years I've never been so happy with how they are doing. No complaints whatsoever. The team communicate well. Although I do want them to get their own place, I would love them to stay at Loch View as they are safe there. They can be challenging but staff understand them. They have a lot of activities and have started new ones."

Since our last visit there were several changes to personnel due to retirement but also some restructuring of the management team. Each house we visited was generally calm, and we witnessed staff being confident, warm and caring during their interactions with individuals.

Nine people receiving treatment were classified as having a 'delayed discharge'. This occurs when an individual is clinically ready, however, unable to leave hospital. We were told that a lack of appropriate accommodation for complex needs and care provision in the community was the reason for the delays. NHS Forth Valley was taking part in a pilot study in relation to the National Support Panel (NSP) under the 'Coming Home' work that will establish statutory processes in relation to the oversight of people who are delayed in hospital.

The Scottish Government's [Coming Home Implementation report](#) identified the need to improve national and local monitoring of those at risk of hospital admission or inappropriate placements, and the 'Dynamic Support Register' was launched to support local planning, decision making and improve the visibility of this group of people at risk at local and national levels.

Prompted by Public Health Scotland data, the Commission highlighted that many people with learning disability and complex needs remain in hospital longer than

necessary. Consequences of this can lead to a loss in peoples' levels of independence and community connections. The Commission's Hospital is not home report, published in January 2025 examined the circumstances of 55 people across Scotland with learning disability or complex needs who had been in hospital for 10 years or more.

We were told of recent restructuring of the management team with an emphasis on delivering improvement on delayed discharge. Previously the service manager post had been occupied by health, but this was now shared between health and social work for further oversight. With the addition of social work, it was anticipated there would be increased focus and coordination to expedite community care packages. Dynamic discharge meetings continued weekly to monitor and manage progress.

Recruitment was ongoing for staff nurse and health care support worker (HCSW) vacancies arising from shortages due to several staff reaching retirement around the same time. It was acknowledged there had been a loss of experience, but newly registered staff were described as "very eager to be in their roles." The feedback from staff on the day was that they were happy being there. One person had experience in the unit initially as a student nurse and was happy to accept a post and liked their job. It was highlighted by some that staff shortages could result in there only being one registered nurse on duty in each house and a further concern expressed that there had been occasion where one house may not be covered by registered staff on nightshift due to shortages. This was concerning to hear, so we discussed this with the SCN who acknowledged that this had happened and had been escalated to senior managers, but was not a regular occurrence.

To manage the shortfall in nursing staff, redeployment from other clinical areas had been used. For mental health staff unfamiliar with this environment, we were told that an induction was completed with 'shadow shifts' offered until personnel felt competent working in this environment.

Care, treatment, support, and participation

Individuals are admitted to the unit for assessment and treatment. On admission to the unit a care plan is devised with specific treatment goals which encompasses physical health monitoring, mental health and behavioural needs.

An MDT approach is taken to ensure that these needs can be addressed to achieve a successful discharge. Therapeutic activity, physical health monitoring, risk assessment, communication needs, skills achievement and positive behavioural plans are developed. Information is gathered from relatives and welfare guardians where available in addition to seeking the individuals' views.

We were aware of one individual who had been living in the seclusion suite for several years but heard and saw this being referred to as segregation instead of

long-term seclusion. The goal was to get this individual reintegrated to the wider unit and we were pleased to note some positive change in the past year where they had managed to make some progress. The use of the word segregation is mainly noted in prison settings; the Commission consider the terms seclusion to be a more appropriate term in hospital/care services.

Care records

Care plans, MDT records, risk assessments and legal documentation were located on the electronic 'Care Partner' recording system. The contact records provided detail in relation to general presentation, interventions and support required, activities, physical health and medication. There was evidence of input from all members of the MDT including music therapy.

In addition, the documentation provided information regarding daily activities, engagement with staff-led interventions, and participation in structured or leisure-based activities. Overall, documentation reflected views of individuals and their relatives/guardians, so it was clear these were being sought. There was also consistent recording of contact with family members and involvement with other professionals, which supported a holistic overview of ongoing care and support.

While the variety of records held a wide range of information, we found some care plans to be written mainly as bullet points which did not provide a comprehensive overview of the care goals and interventions required to meet these. The care programme approach (CPA) documents were more informative about the care plan. Information was available across the records in meeting minutes and psychological formulations, but these sources were not consistently aligned with the stated care plan outcomes. In one record we could not find strategies for verbal and physical deescalation techniques without searching elsewhere in the records.

Given that nursing staff were being redeployed to Loch View from other clinical areas we felt this fragmented approach could make it challenging to obtain a coherent overview of care, treatment and risk management strategies. The team recognised that the current system could be "clunky", so additional documentation was made available to staff. We were told this was kept in the nursing office and had more details on what to do in terms of actions, language to be used to support an individual and their specific needs. Information would be shared at handovers. Specific information was also available on whiteboards in individuals' rooms. New staff were given induction and shadow shifts prior to being on their own.

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.

Recommendation 1:

Managers should consider developing a more cohesive, person-centred and outcome focussed care planning approach to ensure continuity of care, reflecting positive behavioural support principles and clearly evidences progress towards community transition.

Recommendation 2:

Managers must ensure the regular audit process of the care records so recorded information reflects the detail of interventions being delivered.

The level of detail in the risk assessments was variable with some recording more comprehensive information than others. Although risk assessments were discussed at weekly MDT meetings, there was limited evidence of formal review or systematic updating of the risk assessment documentation to reflect ongoing discussion, changing presentation, or evolving risk management strategies. We found one that had not been updated since March 2025.

Recommendation 3:

Managers should ensure documentation of assessment of risk is current and ongoing.

Multidisciplinary team (MDT)

The weekly meetings were well attended and included full multidisciplinary representation with input from all members of the MDT and evidence of who attended. This included the consultant psychiatrist, speciality trainee doctor, pharmacy, nursing, psychology, dietician and occupational therapy (OT). On the day of the visit, one of the Commission visitors was invited to attend and observe the meeting.

Review of weekly MDT documentation demonstrated evidence of regular multidisciplinary discussion, collaborative decision-making, and ongoing consideration of discharge planning. We were pleased to see evidence of more proactive discharge planning with increased involvement from social work and active pursuit of community-based placement options. The MDT template used was of a good standard and provided a structured format for recording key information, including legal status and whether advance statements had been made or whether there was legal guardian or named person involvement. In addition to the MDT template, there was an action plan for everyone providing a 'snapshot' so that

¹ *Person-centred care plans good practice guide*: <https://www.mwscot.org.uk/node/1203>

specific action could be discussed at the meeting and followed up at the next meeting.

There was evidence of care plan updates, discussion on the individual's presentation and activities undertaken. These included engagement with staff, leisure activities, discussions relating to physical health, occupational therapy (OT) involvement focussing on skill-building, mobility reviews, and speech and language therapy (SALT) involvement. MDT discussions demonstrated appropriate sharing of information and ongoing review.

Observation levels were discussed at the weekly meetings and the rationale for their use documented. This demonstrated consideration of risk management and individuals' safety. There was also evidence that the MDT sought to reduce restrictive practices where clinically appropriate and safe to do so, indicating an ongoing focus on least restrictive principles. Continuity of engagement with community support staff was also encouraged.

Use of mental health and incapacity legislation

On the day of the visit, 10 people were detained under the Mental Health Act. Detention paperwork was accessible on Care Partner, and it was evident where a curator ad litem had been granted. A curator ad litem is a legal representative appointed by the court to represent the best interests of a person who lacks the mental capacity to make decisions for themselves during legal proceedings.

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. We found certificates authorising treatment (T3) under the Mental Health Act were in place where required but noted that 'as required' medication had not been authorised for two people. On discussing this with the responsible medical officer (RMO) it became clear that the documentation in the folder was not the most recent authorisation available. The SCN agreed to access the T3 certificate from Care Partner and place this in the folder kept for reference by nursing staff.

Recommendation 4:

Managers should ensure that printed copies of T2/T3 certificates, are the most current to ensure medication is administered in accordance with legal requirements.

For people who had covert medication in place, appropriate documentation was completed, but one erroneously stated that a person was prescribed an anxiolytic medication which was no longer being prescribed. The RMO agreed to action this.

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

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. Documentation for individuals subject to the AWI Act was available. We discussed with the team that although treatment plans were completed, some could have included more specific treatment information.

Nine people were subject to welfare guardianship orders and there was documentation evidencing the process commencing for one other. In one we saw where a review of the welfare guardianship order had been undertaken to ensure sufficient legal powers were in place to support a proposed community care arrangement being considered.

Rights and restrictions

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 somebody is a specified person 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 the corresponding documentation had been completed along with a reasoned opinion given for its necessity.

We saw active involvement from the Forth Valley Advocacy and were told of good links and that they were a responsive service.

An advance statement is a written statement made by a person while they are well, setting out how they would prefer to be treated or not treated if they experience a mental disorder and their decision-making capacity becomes significantly impaired. The health board also promoted advance statements when writing to individuals with information about the Mental Health Act. The unit admission pack also included information about this in easy read format.

Activity and occupation

We were pleased to see that there continued to be a broad range of social and leisure activity available throughout the week. There was input from OT for assessment and skills attainment, music therapy, outings, and nurse led activity.

² Covert medication good practice guide: <https://www.mwcscot.org.uk/node/492>

Daily continuation records recorded activities engaged in including sensory activities in the snoezelen room.

The physical environment

Each house was clean, bright, smelled fresh, and was welcoming. The environment was calm when we visited. We saw respectful interactions and modelling of behaviours. Apart from the seclusion suite and pod, the houses consisted of single rooms each with toilet, sink and showering facilities. There was also access to a communal bathroom which some people preferred.

Some rooms were very personalised, and we saw one decorated with wallpaper chosen by the occupant and decals on corridor walls outside other rooms.

There were also gardens for individuals to enjoy outdoor space, and we were able to see people accessing these areas.

Any other comments

Throughout the visit we witnessed some warm and engaging interactions between staff and individuals; it was clear the team worked well together to provide care and treatment for this group of individuals who had very complex needs and behaviours that could regularly challenge.

From speaking with staff and seeing the level of detail in the care records it was evident they knew these individuals very well. We were pleased to see continuing improvement for the individual in seclusion and that progress was starting to be made towards discharge planning for some others.

Summary of Recommendations

Recommendation 1:

Managers should consider developing a more cohesive, person-centred and outcome focussed care planning approach to ensure continuity of care, reflecting positive behavioural support principles and clearly evidences progress towards community transition.

Recommendation 2:

Managers must ensure the regular audit process of the care records so recorded information reflects the detail of interventions being delivered.

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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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