Mental Welfare Commission for Scotland

Report on announced visit to:
Rohallion Clinic, Vaara Ward, Muirhall Road, Perth, PH2 7BH

Date of visit: 26 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

Vaara is a 12-bedded, medium secure ward, based at Rohallion secure care clinic. The ward provides recovery and rehabilitation for adult males. Individuals admitted to this ward are primarily from the north of Scotland but can also be from out with this area.

On the day of our visit, there were 11 people on the ward and one individual was expected to be transferred to Vaara soon.

We last visited this service in January 2024 on an announced visit and made recommendations on care plans being person-centred, that psychotropic medication should be legally and appropriately authorised and that anti-ligature work was to be progressed and completed. The response we received from the service was that person-centred care plans had been established, audits were carried out to highlight areas of improvement and all new nursing staff were trained in the use of the person-centred standards for care plans. Each consultant psychiatrist, the clinical team and nursing staff carry out audit processes to check that T2 and T3 certificates are relevant, accurate and current. The Rohallion secure care clinic service would continue to liaise directly with external estate contractors regarding the time scales for the anti-ligature work.

On the day of this visit, we wanted to meet with people receiving care and treatment on the ward, speak with any of their relatives and follow up on the previous recommendations.

Who we met with

We met with, and reviewed the care of nine people, four of whom we met in person, and we reviewed five sets of care records. We also met with two members of staff.

We spoke with the general manager, head of medium secure nursing, the consultant forensic psychiatrist, the charge nurse and the occupational therapist (OT),

Commission visitors

Gordon McNelis, nursing officer

Sandra Rae, social work officer

What people told us and what we found

The individuals we spoke with on the day of our visit gave mixed feedback about the staff, the ward and activities.

Individuals told us they were “well looked after”, “staff support me well”, “I’m happy with my progress” and “I get on well with staff”. While others told us “It doesn’t feel like there is a good relationship with the consultant and nursing staff”, “the change in consultants has had an impact on my care and treatment” and “there is a lack of compassion”. We also heard “Vaara is a good ward” but “there shouldn’t be a shortage of nursing staff, this has a negative impact on the general running of the ward”.

We were told “activities aren’t as robust as they were in the past”, “the level of activity isn’t good” with alternative views such as “activities are excellent”.

We heard positive comments from staff, in that they liked working there and that it was a good ward with good staff.

Care, treatment, support, and participation

On the day of our visit, we wanted to follow up on our previous recommendation regarding care plans being person-centred. The transfer to person-centred care plans was evident and we found the new format had helped to improve the standard of care planning. Care plans were robust, clear, descriptive and focussed, with risks clearly identified and detailed interventions and guidance throughout; they included an introduction and detailed summary of the individual which gave the reader a good understanding of the person’s circumstances and their historical and current areas of need.

Care plans were regularly reviewed and it had been documented whether the individual did not wish to sign or take a copy. We were told that care plans were audited monthly by the Band 5 and 6 registered mental health nurses (RMNs). Audit results were then shared with ward staff either verbally or by email and notes were added to the care plan to provide the auditor’s feedback. We heard that nursing staff had discussions with ward managers regarding any issues or concerns that were identified.

Care records

Information on individuals’ care and treatment was held electronically and easily located on the EMIS system.

We were told some security documents such as suspension of detention records and medical treatment forms were also stored as hard copies. Our review of these records showed the daily entries were robust and contained detailed clinical

information that described the presentation of the individual and gave the reader a good understanding of the individual's day.

We were advised that one-to-one discussions between named nursing staff and individuals took place regularly however, we found these difficult to find in the daily continuation notes. Although we saw evidence of these discussions taking place during care plan reviews, albeit less frequently than would be expected; we would have expected that a record of all one-to-one contact between the individual and their named nurse to be documented in continuation notes and for a record made of when these sessions were offered and whether the individual accepted or declined to participate in these discussions.

We found examples in continuation notes of recorded discussions that took place between OT colleagues and the individuals during their engagement in activities.

Multidisciplinary team (MDT)
A range of professionals were involved in the provision of care and treatment in the ward. This included psychiatry, nursing staff, OT, an activity support worker (ASW) and psychology.

Individuals had access to a general practitioner (GP), pharmacy, physiotherapy, dietician, podiatry and advocacy services. We were told there was a dedicated social worker for medium secure services that initially had been in post at Rohallion Clinic however, due to discontinued funding, this was no longer in place. We considered this to be a gap and that this key role would be beneficial for communication with services in and out with the Tayside area. We were advised that further consideration will be given to this.

We found the MDT meeting proforma provided detailed content, giving the reader a good understanding of what had taken place at the meeting. MDT meetings took place every two weeks and there was a record of those in attendance, which included who had been invited to attend the meetings and had attended. We found that the views of the individual were gathered during one-to-one discussions, prior to the meeting taking place.

Care and treatment in Rohallion was reviewed under the Care Programme Approach (CPA). CPA is a framework used to plan and co-ordinate mental health care and treatment and there is involvement of a range of different professionals, with the aim of keeping the individual and their recovery at the centre of this approach.

For certain groups of people, enhanced CPA can be used as a mechanism for regular review of their care, treatment, needs and risk management. We found the CPA documents had detailed, summarised content from all the disciplines that were involved. We found these were future-focused while taking into consideration positive risk taking.

We found risk assessments and risk management plans contained in the CPA documents to be robust and thorough, giving a detailed overview of identified historical and current areas of risk.

Use of mental health and incapacity legislation

The individuals on Vaara ward were all subject to restrictions of medium security and detained either under the Mental Health Care and Treatment (Scotland) Act, 2003 (Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (CPSA).

All documentation relating to the Mental Health Act and CPSA were found in both electronic and paper format.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained and are either capable or incapable of consenting to specific treatments. On the day of our visit, we wanted to follow up on our previous recommendation that all psychotropic medication be legally and appropriately authorised and that regular auditing by clinical staff was taking place.

The Rohallion Clinic action plan response to this recommendation was that the prescribing psychiatrists, clinical team and nursing staff carried out audit processes to verify that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act, were relevant, current and accurate.

During our review of T2 and T3 certificates, we found the electronic versions for these stored on hospital electronic prescribing and medicines administration (HEPMA) system. Duplicate paper copies were also found that matched with the electronic versions. We found a discrepancy on a T2 certificate that was in an individual's documentation when they had been transferred from another hospital to Vaara ward. We raised this with the charge nurse on the day of our visit who advised that they would bring this to the attention of senior medical staff in Vaara and the transferring hospital ward.

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. During our review of a section 47s, we found the certificate to be in place, but we could not find the accompanying guardianship order. This was raised with staff, with advice to include a copy of this electronically and in paper format in the individual's care records.

Rights and restrictions

As a forensic medium secure ward, Vaara continued to operate with a locked door which was proportionate with the level of risk identified with the patient group. We noted that there was a locked door policy was in place.

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. We found five advance statements on file and all were signed by the individual.

We were told advance statements were promoted in the ward and that staff discussed these with individuals at an appropriate time during their admission. We saw evidence in the notes of these discussions taking place, which included whether the individual had accepted or declined the guidance offered by staff.

Activity and occupation

Vaara had activities facilitated by its own OT and ASW. We saw thorough OT assessments that were carried out soon after admission, to identify the individual's likes, interests and needs in relation to their daily living skills.

There was a weekly activity timetable that linked with identified areas of need and interests and this included information from SCAPA, the Rohallion Clinic patient activity and therapy centre. Other available activities included opportunities to attend information technology (IT) groups, education, and arts and crafts groups. There was focus on physical exercise groups with access to the gym, the sports hall and the outdoor football pitch; there was also a gardening group.

Activities also took place in the local area, with individuals having access to the Perth hillwalking group and the local library. We saw evidence of detailed activity planning that was meaningful, structured and person-centred however, care records showed limited participation in these. We felt that participation in activities was not recorded in the care records as robustly as it could have been.

Recommendation 1:
Managers should ensure that activity care records include a rationale for the activity taking place, a description of the individual's level of participation and presentation during this time and document whether an individual accepts or declines to participate.

We were told nursing staff provided activities both on and off the ward during evenings and weekends. These included escorting individuals in the clinic grounds and in the community however, a reduction in nursing staff to accommodate these

had had an impact on the availability and frequency of evening and weekend activities that took place.

The physical environment

The layout of the ward consisted of single en-suite rooms, a main communal area that made good use of space and was bright with good lighting, with access to a lounge, dining room, a designated space for activities, a therapy kitchen and visitor's room.

Although we saw posters signposting individuals and visitors to helpful internal and external resources, the posters were tired looking and would have benefitted from being replaced with newer versions; this was raised with senior ward staff.

There was access to internal courtyards and to a large, shared garden area in the grounds of the clinic for individuals to use at designated times. We saw a wellbeing room for staff situated at the external entrance to the ward. We found this to be a positive opportunity for staff and could see the benefits that this could provide staff, but unfortunately, we saw water damage to the ceiling area, that not only disrupted the environment, but raised health and safety concerns. We raised this with staff who told us that although they had escalated this to the external property and facilities management provider, they had not as yet been a response.

Recommendation 2:
Managers and the relevant property and facilities management provider should ensure outstanding repair and refurbishment work is undertaken as soon as is practicable.

On the day of this visit, we wanted to follow up on a recommendation that had been repeated on previous visits with regards to anti-ligature work and ensuring that door top alarmed doors to side rooms and en-suites are installed. We were disappointed to be told that this phase of NHS Tayside anti-ligature work had yet to be started, despite being a repeated recommendation. This is the second time we have repeated this recommendation and shall escalate this to senior managers in Tayside.

Recommendation 3:
Senior managers and the relevant property and facilities management provider must ensure timescales for this outstanding anti ligature work are identified and work undertaken as soon as is practicable.

Summary of recommendations

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Managers should ensure that activity care records include a rationale for the activity taking place, a description of the individual's level of participation and presentation during this time and document whether an individual accepts or declines to participate.

Recommendation 2:
Managers and the relevant property and facilities management provider should ensure outstanding repair and refurbishment work is undertaken as soon as is practicable.

Recommendation 3:
Senior managers and the relevant property and facilities management provider must ensure timescales for this outstanding anti ligature work are identified and work undertaken as soon as is practicable.

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.

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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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