Mental Welfare Commission for Scotland

Report on unannounced visit to:
Rohallion Clinic, Esk Ward, Muirhall Road, Perth PH2 3PT

Date of visit: 18 September 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

Esk is a 12-bedded, low secure ward that provides assessment, recovery and rehabilitation for adult males. Esk is a regional unit based at Rohallion secure care clinic. Individuals admitted to this ward are primarily from the north of Scotland but can also come from out with this area.

On the day of our visit, there were nine people on the ward and three vacant beds.

We last visited this service in February 2023 on an unannounced visit and made recommendations around care plans being person-centred, that continuation notes were audited to ensure they are person-centred and met Nursing and Midwifery Council (NMC) standards, that person-centred activities were offered to individuals and for the service to consider appointing a dedicated activity coordinator.

The response we received from the service was that the quality improvement team in Rohallion secure care clinic service were restructuring the care planning process using the NHS Tayside care plan standards, audits were being 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, with senior nursing staff who would be available to support staff, and implement education sessions to review terminology used in the continuation notes. There was a pilot project for activity to be explored, with a view to how this would be implemented in the person centred care plans.

On the day of this visit, we wanted to follow up on the previous recommendations and speak with people receiving care and treatment on Esk Ward.

Who we met with

We met with, and reviewed the care of seven people, four who we met with in person and three who we reviewed the care records of. We also met with two members of staff.

We spoke with the general manager, the head of nursing for low secure, charge nurse and consultant forensic psychiatrist.

Commission visitors

Gordon McNelis, nursing officer

Lesley Paterson, senior manager (East team)

What people told us and what we found

We met with several individuals on the day of our visit and heard common themes relating to the admission and rehabilitation model of care in the ward and how the unique needs of this mixed group of individuals had an impact on the ward, the staff and individuals.

Some people believed this had caused a “split in patients” that created barriers and affected the relationships with staff. We were told “staffing is never enough”, “the ward needs specialist staff for this specialist unit; without this, it leads to conflict amongst the patients and towards staff”, “staff are stressed out” and “day-to-day care is brilliant but the amount of staff could be better; I see fatigue in staff”.

Other comments we heard were “the lack of staff impacts on the amount of activities I can do”, “a lot of these staff are excellent, but I don’t get on with all of them” and “I like the staff, they’re helpful, warm hearted, caring and motivating” and that “activities are good in the ward”.

Care, treatment, support, and participation

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

During our visit, NHS Tayside were preparing to transfer all information to the alternative MORSE system. On the day of our visit, we wanted to follow up on our previous recommendation regarding all care plans being person-centred, showing evidence of individuals participating in their development, being regularly reviewed and their quality audited.

Since our last visit to Esk, the leadership team for Rohallion secure care clinic had devised and restructured a new care planning process using the NHS Tayside care plan standards. In our review of care plans, we found these included an introduction and detailed summary of the individual which gave the reader a good understanding of their circumstances and historical and current needs.

The transfer to person-centred care plans was evident and we found this new format to be of a good standard. They were robust and informative and included detailed guidance and direction with interventions. The care plans linked with the identified risks and areas of need from risk assessments, admission assessments and from intelligence gathered from individual’s previous engagement with NHS services.

One individual we spoke with felt it would have been beneficial for their partner to be included in developing their care plans however, we saw clear evidence of individuals contributing to their care plans, as previously recommended in our last report. Individuals we spoke with said they either had a copy of their care plan or could get one if they requested and care plans were regularly reviewed.

Care records
During our review of the continuation notes, we found these to be of a variable quality. Although the notes met the expected Nursing and Midwifery Council (NMC) professional standards as previously recommended, we found some entries contained brief information and lacked clinical descriptions. We believe it is necessary for health professionals to be descriptive when recording clinical information and give a clear account of whether a person's mental health is showing signs of improvement, deterioration or is unchanged.

Recommendation 1:
Managers should ensure nursing staff document clinical descriptions of an individual's presentation in case records.

Recording of one-to-one interactions between individuals and all multidisciplinary team (MDT) disciplines were clearly documented in notes. We found these to be detailed and they gave a good impression of the individual's situation and circumstances.

Multidisciplinary team (MDT)
The MDT for Esk Ward consisted of nursing staff, psychiatrists, psychology, dietetics, occupational therapy (OT), social work and other allied health professionals.

We reviewed the MDT meeting records and found these were well documented and gave the reader a good impression of the individual's presentation since the last meeting. The individual's views were clearly recorded and included information that captured subsequent discussions and defined action points.

During our visit, we received feedback that highlighted there was a common theme of issues linked to Esk Ward functioning as both an admission and rehabilitation service. Some felt that this dual model of care had an impact on the rehabilitation of individuals, as clinical acuity and risk management took priority; the delivery of care in this environment had resulted in some individuals "getting lost" in the ward.

We also heard how the high levels of acuity in this environment had become routine and that this contributed towards staff retention difficulties, which had implications for the skill mix on the ward.

Use of mental health and incapacity legislation
On the day of our visit, all individuals were detained either under the Mental Health Care and Treatment (Scotland) Act, 2003 (Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (CPS Act).

The individuals we met with were aware, and had a good understanding, of their rights under the legislation. We were told that these had been explained to them

during admission and also latterly during their inpatient stay when their mental health had improved and they were able to better understand this information.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained and who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were reviewed on the day of our visit. We found discrepancies on some T2 and T3 certificates and identified medication that was not legally authorised. We raised this with senior medical staff who advised that they would review these treatment plans as a priority and take any appropriate action.

Recommendation 2:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised and a system of regularly auditing compliance by all key clinical staff is put in place.

There was one individual who was subject to a welfare guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). Where an individual lacks capacity in relation to decisions about medical treatment, a section 47 certificate should be completed under the AWI Act and 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.

On reviewing the care records, we found an appropriate section 47 certificate in place, however the accompanying treatment plan was missing. This was addressed with ward staff with a view to have this rectified. We were satisfied would be addressed.

Rights and restrictions

As a low secure ward, Esk continued to operate a locked door policy which was proportionate to the level of risk identified with the individual group. A locked door policy was in place.

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 designated a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

We were told that all individuals in Esk ward were assigned specified persons status however, we found no reasoned opinions for these restrictions and that not all individuals had been formally advised of their designated specified person status. If the RMO considers it necessary to apply specified person restrictions on individuals,

we would expect this to be supported with a reasoned opinion for everyone. The Commission would therefore expect restrictions to be legally authorised, the need for specific restrictions to be regularly reviewed and that individuals are made aware of the reasons for the application of these restrictions.

Recommendation 3:
Managers should undertake an audit to ensure that all restrictions are required, proportionate, and legally authorised under specified person's legislation and there is evidence of regular review.

Recommendation 4:
Managers should ensure the RMO records their reasoned opinion, and that management have communicated the RMO's explanation and rationale to the individual (where appropriate), their named person if they have one, and the Commission.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[1].

Activity and occupation

On the day of our visit, we wanted to follow up on our previous recommendation regarding activities being person-centred and for consideration to be given to appointing a dedicated activity coordinator.

During our review of activity-based therapy and ward activities, we heard mixed feedback however, this was predominantly related to the lack of person-centred activities. Individuals told us "there are no staff to facilitate activity sessions", and we heard that they would like to have activities that linked with their interests, that person-centred activities would benefit from more funding and availability, and that individuals are not always able to have escorted time out from the ward "due to lack of staff and other things being prioritised".

We were told that planned evening activities were regularly changed or cancelled at the last minute which had resulted in a complaint being lodged. We did hear some comments that "activities in this ward are good", that there was focus on physical activity with regular access to the gym and the football pitch. Although there was an OT therapy kitchen, access to this could be limited due to the variety of needs of individuals on the ward.

We were advised that no activity coordinator was in place although a pilot project was in operation to identify person-centred activities by exploring individual's needs to match these with suitable activities. Although this was ongoing and its

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

effectiveness had not yet been assessed, we would encourage the results to be considered by managers so that activities and occupation tailored to individual need are available in the ward.

Recommendation 5:
Managers should ensure that there are a range of person-centred activities on offer and should consider appointing a dedicated activity co-ordinator.

Although we found a description of the activities that had taken place in the care records, we noted these were brief. Entries in the care records should contain an observation of the individual's presentation and level of engagement, and their participation during the activity, including information on whether the individual accepted or declined to participate. We raised this with managers at our end of day feedback meeting.

The physical environment

The layout of the ward consisted of 12 single en-suite bedrooms. The ward had a central outdoor courtyard area that individuals could access during the day. There were meeting rooms, dining areas and other separate rooms that were used as visitor rooms; these could also be used as an area for managing individuals who were experiencing distress.

There were communal and wellbeing areas and an activity area with a pool table, TV and video games for individuals to use.

Summary of recommendations

Recommendation 1:
Managers should ensure nursing staff document clinical descriptions of an individual's presentation in case records

Recommendation 2:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised and a system of regularly auditing compliance by all key clinical staff is put in place.

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Managers should ensure the RMO records their reasoned opinion, and that management have communicated the RMO's explanation and rationale to the individual (where appropriate), their named person if they have one, and the Commission.

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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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