Mental Welfare Commission for Scotland

Report on announced visit to:
Strathmartine Centre, Flats 1, 2 and 3, Craigmill Road, Dundee, DD3 0PG

Date of visit: 10 November 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

Strathmartine Centre has learning disability (LD), inpatient units known as Flats 1, 2 and 3.

Flat 1 is a low-secure environment for eight male patients who a history of offending behaviour. Flat 2 is occupied by one individual and there were two individuals occupying Flat 3's behavioural support and intervention unit (BSIU).

The Strathmartine Centre therapeutic area, Craigmill Skill Centre, has an adapted living space to provide enhanced care for one individual who was due to be transferred to Flat 3 (BSIU).

On the day of our visit, there were 12 individuals receiving care across the Strathmartine Centre site and no vacant beds.

We last visited this service in May 2024 on an unannounced basis and made recommendations that multidisciplinary team (MDT) meetings were fully recorded, MDT meeting pro formas were completed, that individual and carer involvement was promoted where appropriate, that those whose discharge was delayed had their discharge planning activity monitored and recorded, that there was a service wide supported approach to discharge planning which was considered at the point of admission and that these cases were discussed during MDT meetings.

We recommended that consideration was given to the involvement of a discharge coordinator to help identify potential barriers and suitability of accommodation for individuals' discharge into the community. Another recommendation noted that the correct terminology should be used in line with the Commissions good practice guide on the 'use of seclusion', that regular external reviews of those subject to seclusion took place and that the review of NHS Tayside's seclusion policy was progressed to ensure it supported the restrictive practices in place, including the use of CCTV. We recommended that activities were person-centred and reflected the individual's specific preference and care needs, and that there was availability of equipment to enable meaningful and therapeutic intervention/activity.

With regards to the environment, we recommended that an urgent decision be made regarding the estate and whether it would be significantly upgraded, or moved to an alternative, more suitable accommodation. We recommended that outstanding repair and refurbishment work was undertaken as soon as was practicable and that Flat 3 reception area was made welcoming, fit for purpose and that there was a programme of work, with identified timescales to address the environmental issues.

The response we received from the service included a detailed action plan addressing all thirteen recommendations, with actions to be put in place to address and support improvements in all of the above.

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

Who we met with

We met with seven people and reviewed their care records.

We spoke with the general manager, two senior charge nurses (SCNs), the clinical director and we met with advocacy.

Commission visitors

Gordon McNelis, nursing officer

Tracey Ferguson, social work officer

Dr Sheena Jones, consultant psychiatrist

Dr Rachael Lee, ST6 psychiatrist of intellectual disability

What people told us and what we found

Although there was limited opportunity to engage in any detail with the individuals, due of the extent and impact of their disabilities, overall, we gathered a general theme of positive feedback about staff. We were told “staffing is fine”, “staff helped”, “staff are nice” and “I like having staff to talk to”. In addition to these comments, all individuals we spoke with said they did not want to move to the proposed relocated site at Murray Royal Hospital in Perth.

Individuals told us they were aware of their care plans, that they knew about their rights and were comfortable using advocacy services and contacting their solicitor. Other comments that we heard from individuals were that they had a good level of activity and structure which included getting “out and about” into the local area with escorted time out, which they valued. We were told the ward environment “can be noisy” and were given an example of doors banging. The general view was that the ward was comfortable.

Care, treatment, support, and participation

Information on individuals care and treatment was held electronically on the MORSE system. We reviewed several care plans and found these to be person-centred, detailed and they included clear, individualised needs and guidance on the interventions for the reader.

The care plans promoted and encouraged independence; they included the named person views in the development of the care plan. One individual we spoke with, brought a copy of their care plan for us to review. We found this included information on discharge planning, although the version they had was not in an accessible read format. We found accessible read versions of care plans in the BSIU and felt it would be beneficial for discharge planning information to be available for other individuals in this format too.

Care records

During our review of the continuation notes, we found these to be of mixed quality. Some included a description of the individual’s mood, behaviours and level of engagement, while others were brief, repetitive and the clinical description was lacking. We believe it is necessary for health professionals to be descriptive when recording clinical information and to give a clear account of an individual as observed during routine observation.

Recommendation 1:

Managers should ensure nursing staff include clinically descriptive information of an individual’s presentation in case records.

Care and treatment was reviewed under the care programme approach (CPA). CPA is a framework used to plan and co-ordinate mental health care and treatment, with a

particular focus on planning what will be provided, by involving different professionals and by keeping the individual and their recovery at the centre. For certain groups of people, an enhanced CPA can be used as a mechanism for regular review of their care, treatment, needs and risk management.

CPA documents for people detained under a compulsion order with restriction order (CORO) are mandatory but we had difficulty finding these. We were told that due to the recent transition of electronic records from EMIS to MORSE, some documents had not yet been transferred, however we were assured this process was ongoing and that relevant information would be transferred as soon as practicable.

Those we did find varied in quality. Although CPA meetings provided an opportunity to discuss discharge planning with the wider MDT, the detail of the documented discussion of this taking place was minimal. Despite delayed discharges being discussed at MDT meetings and discharge planning reviews, we could not find this information included in the available CPA documents.

Recommendation 2:
Managers should ensure that CPA meetings and documentation include discussions and details on the progress of an individual's delayed discharge and planning around this.

Multidisciplinary team (MDT)
The centre had a broad range of disciplines available. This included a consultant psychiatrist, registered learning disability nurses (RLDN), registered mental health nurses (RMN), health care support worker (HCSW), activity support workers (ASWs), occupational therapists (OTs), OT assistants, psychologist, physiotherapist, dietician and speech and language therapist (SALT). Some of these allied health professionals (AHPs) attended the MDT meetings at times and had direct input into individual care through a referral system.

On the day of our visit, we wanted to follow up on our previous recommendation regarding MDT meetings being fully recorded. We reviewed the MDT meeting records and found that these had an updated summary from the previous meeting and provided a clear overview of the discussions that took place.

We were told that individuals were updated of any changes from the MDT in a way that was possible for them to understand. Advocacy attended the weekly MDT meeting to raise any concerns from individuals. Although individuals and their relatives were invited to the MDT meetings, most families discussed any concerns with ward staff and very few attended the meetings.

During our visit, staff interactions with individuals showed warmth, commitment and positive engagement. We observed staff that were knowledgeable and skilled in delivering care and treatment. In the flats, staff were observed providing supportive,

attentive and responsive interactions with the individuals. When we were in contact with the staff team, there was a sense of uncertainty about the planned transfer of services. Additionally, the feedback we received from individuals during our meetings with them reflected similar concerns, highlighting that the transfer of services was also creating a period of uncertainty for them.

On the day of our visit, we wanted to follow up on our previous recommendation regarding discharge planning for individuals whose discharge has been delayed. We were told there was a weekly discharge planning review with the MDT and the associated health and social care partnership (HSCP) leads. The review was also attended by the identified community service provider, and the views of the individual and their carers were gathered and discussed.

We also heard that a discharge coordinator post had been advertised for recruitment, although no preferred candidate had been identified from the interview process; recruitment to the post was ongoing, with Dundee HSCP leading this. During our review of the care records, we found evidence of delayed discharge discussions.

Use of mental health and incapacity legislation

On the day of the visit, all 12 people in Flats 1, 2 and 3 were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (CPSA). All documentation relating to the Mental Health Act and CPSA were available.

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. Of the 12 individuals detained, 10 required either consent to treatment certificates (T2) or certificates authorising treatment (T3) to be in place.

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. Two T3 certificates had expired, resulting in individuals receiving treatment without the legal authority in place and one T3 certificate contained a medication dose that exceeded safe prescribing limits.

If urgent medical treatment is required by an individual and the treatment is not covered by a T2 or T3 certificate, Section 243 of the Mental Health Act sets out the circumstances and grounds for when it could be given. Section 243 requires the individual's RMO to retrospectively notify the Mental Welfare Commission within seven days of any treatment that was given under Section 243, by completing a T4 certificate. The RMO authorising the treatment should record clearly in the individual's care records why the treatment was urgently necessary.

We raised the issues we found and followed this up with senior medical staff who assured us that consideration had been given as to whether the medical treatment should continue until a designated medical practitioner (DMP) attended the Strathmartine Centre to complete a new T3 certificate that would lawfully authorise treatment. We did not receive T4 certificates for these cases and have continued to follow this up with the medical staff concerned. We requested that the individuals affected by this be formally advised of this error, of their right to seek legal advice, and that they receive information and advice regarding the complaints procedure.

We noted there was no prompt included on the HEPMA system to alert the staff who were administering medication of the expiry dates of T3 certificates. Additionally, the audit process failed to identify expired or soon to expire T3 certificates. We have recommended that an improved notification and audit process of all authority to treat documents is implemented; this should alert the relevant staff of the expiry dates of these legal documents.

Recommendation 3:
Managers and members of the multidisciplinary team (medical, pharmacy, and nursing staff) must ensure that all psychotropic medication is legally and appropriately authorised. An audit and notification system should be put in place to ensure compliance with this.

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 section 47 certificates, we found two out of date historical copies from 2023-24 on MORSE. We later found printed copies in the BSIU. We raised this with staff who told us that these would be uploaded to MORSE.

Rights and restrictions

Due to the complex needs of the individuals in the units, a locked door policy was in place. We were satisfied that this was proportionate in relation to their needs.

The Strathmartine Centre had access to advocacy services, which was promoted throughout the Strathmartine Centre. We were told advocacy attended the site on a regular basis and were available to meet with individuals either if directly approach or by request.

We heard they had a supportive relationship with the individuals and were closely involved in providing information and advice about the transfer of services and relocation from Strathmartine to Murray Royal Hospital and Rohallion Secure Care Clinic.

Prior to our visit, we had corresponded with NHS Tayside to follow up on our previous recommendation regarding the review of their seclusion protocol. We were told guidance reflecting the use of CCTV was included in the revised protocol as requested and that this had been signed off.

Additionally, a revised NHS Tayside CCTV protocol was in development due to the previous version not sufficiently reflecting practice in a learning disability service.

Activity and occupation

On the day of our visit, we wanted to follow up on our previous recommendation regarding providing activities that were person-centred and reflected the individual's preferences and care needs.

We saw well-structured OT sessions and activity timetables in pictorial format. All individuals had an activity timetable that was developed by OT. The activities were delivered by OTs, OT assistants, ASWs and nursing staff.

We found the programme of activities which took place in the ward, in the adjacent Craigmill Skill Centre and in the community setting was meaningful, person-centred and included escorted outings to participate in leisure activities. We were told that individuals' likes and dislikes were considered when developing the activity plans and that ongoing discussion took place with the individual, their carers and members of the MDT to ensure the activity plans remained meaningful and individualised.

We were told that talking mats and adapted communication aids were used to support individuals where appropriate and when gathering their views on their activity plans. We reviewed the daily continuation notes and saw that these were detailed and clearly outlined the purpose of activities that took place.

A description of the individual's presentation and level of engagement at that time was included, which gave the reader a good understanding of the individual's level of participation. Feedback from the individuals were positive, with a general view that the activities gave them enough to do however, they did mention that the availability of activities reduced in frequency at the weekend.

The physical environment

On the day of our visit, we wanted to follow up on our previous recommendations regarding the physical environment concerns in Flat 1, Flat 2, Flat 3 (BSIU) and the adapted living area in the Craigmill Skill Centre.

Prior to our visit, we had corresponded with NHS Tayside to follow up on our previous recommendation regarding a decision to be made whether the Strathmartine estate will be significantly upgraded or alternative more suitable accommodation be sourced. We were told that NHS Tayside had agreed for the

transfer of services and relocation of individuals from Strathmartine to Murray Royal Hospital and Rohallion Secure Care Clinic.

We wanted to follow up on our previous recommendation regarding outstanding repair work and refurbishment and that these were undertaken. We were told repair and refurbishment work had been prioritised, with a plan that outlined the identified works, timescales and progress. These environmental improvements will continue to be overseen by estates management and coordinated through weekly site meetings involving site facilities, clinical teams, infection control and health and safety teams.

Flat 1 was separated into two, four-bedded areas with each bedroom having an en-suite toilet and sink. There was a communal shower room in the main hall of the flat. The flat comprised of a lounge, dining room, laundry room and kitchen. We found the reception area welcoming, and throughout the main areas of the flat, it was clean and bright.

We observed the individuals' side rooms, which we found to be homely and comfortable spaces. Flat 1 was linked with Flat 2 by a separate corridor at the rear of the building. Flat 2 had a similar reception area to Flat 1. The layout of the main body of the flat was split into two living areas. Opportunities to engage with the individuals here were limited due to the impact of their learning disabilities. This also restricted our access to observe their living environment.

Flat 3 (BSIU) was spread over a large area that consisted of three separate enhanced care areas. In each of these areas, the individuals had access to a sitting room, a bedroom and toilet and hand-washing area. The open area in the BSIU had a bedroom with separate toilet and hand-washing access. There was a communal lounge area with a dining room and access to a bathroom and shower room.

During our walkaround of Flat 3, we observed an improved and welcoming reception area; this had taken into consideration the sensory issues of the individuals who were cared for in the unit and provided a welcoming space for individuals, staff and visitors to the flat. Each flat had access to an outside garden space.

During our walkaround of the adapted living space in the Craigmill skill centre, we saw obvious improvements to the environment, with additional furniture in place that took into consideration the individual's preferences.

We also observed improvements and a more homely feel to the garden area, with suitable fencing in place that addressed the privacy of the individual. We were pleased to note efforts included the addition of therapeutic activities in the living and garden areas.

Summary of recommendations

Recommendation 1:
Managers should ensure nursing staff include clinically descriptive information of an individual's presentation in case records.

Recommendation 2:
Managers should ensure that CPA meetings and documentation include discussions and details on the progress of an individual's delayed discharge and planning around this.

Recommendation 3:
Managers and members of the multidisciplinary team (medical, pharmacy, and nursing staff) must ensure that all psychotropic medication is legally and appropriately authorised. An audit and notification system should be put in place to ensure compliance with this.

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 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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