mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to:
Carseview Centre, Intensive Psychiatric Care Unit (IPCU), 4 Tom Macdonald Avenue, Dundee, DD2 1NH

Date of visit: 9 December 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

The intensive psychiatric care unit (IPCU) based in the Carseview Centre, Dundee is a 10-bedded, mixed sex unit that provides intensive treatment and interventions to adults from the Tayside area.

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

We last visited this service in March 2024 on an unannounced visit and made recommendations that the named person role was promoted in the ward and individuals were encouraged to nominate a named person, that there was raised awareness and promotion of advance statements and the benefits of these discussed with individuals, and that when activities took place, these should be documented in the continuation notes, including information on whether the individuals accepted or declined to participate.

The response we received from the service was that the nomination of the named person and promotion of advance statements were discussed with individuals during the multidisciplinary team (MDT) meetings, during one-to-one discussions with clinical staff and when developing care plans with individuals. The named person role and benefits of having an advance statement were promoted by posters displayed around the ward and during education sessions.

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 IPCU.

Who we met with

We met with and reviewed the care of three people and reviewed the care records of one further person.

We spoke with the senior nurse, the senior charge nurse, the charge nurse, other nursing staff and the activity support worker (ASW).

Commission visitors

Gordon McNelis, nursing officer

Kathleen Liddell, social work officer

Alison Thomson, nursing officer

What people told us and what we found

We met with most individuals who gave generally positive comments about staff and the unit. We were told that although some initial apprehension was felt on admission, and it could be "noisy during the night", individuals told us they "felt safe" with staff providing a calm and supportive environment thereafter. Individuals told us activities and facilities were "good".

Comments we heard from staff were "I love working here", "it's a fantastically run ward" and "everyone supports one another".

Care, treatment, support, and participation

Information on individuals' care and treatment was held electronically on the MORSE system after NHS Tayside had recently moved from the EMIS system.

We reviewed all care plans and found the quality of these to be mixed. Care plans for recently admitted individuals lacked person-centredness, despite a robust admission assessment that was holistic and thorough, which had identified the individual's care needs, historical and current risks.

We saw care plans included contributions from the individual and their carers.

Although care plan reviews were regular, the information in these varied, with some frequently mentioning "no change", whereas other reviews had more detail. We discussed the quality of care plans with senior staff at our end of visit meeting and advised that the comprehensive information that was gathered during the admission process be consistently used, as set out in the NHS Tayside person-centred care planning standards format, and for reviews to include information in line with person-centred care.

The 'triangle of care' describes a therapeutic relationship between the individual, staff member and carer/relative that promotes safety, supports communication, and sustains the wellbeing of the individual. We were told a new 'triangle of care' self-assessment tool was used to improve and increase the frequency of engagement and communication with carers and relatives, and we found that this contact was reflected in the care records.

Care records

Our review of care records gave a good indication of how the individuals in the IPCU spent their day. We noted some language that described an individual could have been deemed inappropriate – "gloating/smirking at staff". We recognise that interpretation of an observable behaviour can be subjective however, we felt that this was recorded without providing additional information or context to the situation. We acknowledge senior staff response who felt there was context for the use of this

language however, we consider that it is necessary for health professionals to give a clear account of a situation.

We found recorded evidence of regular one-to-one discussions between nursing staff and individuals taking place. Although the uptake of these varied, the information gathered was thorough and included whether the individual accepted or declined to participate.

Responsible medical officer (RMO) reviews were detailed, included the views of the individual, and gave an understanding of the discussion that was taking place.

We wanted to follow up on our previous recommendation regarding the documentation of the activities that took place. During our review of the ASW care records, we found these were robust and included the purpose and rationale of the activities the individual was participating in. These notes included detail of the individual's presentation and their level of engagement and participation at that time.

We noted that the occupational therapy (OT) assessment of occupation was robust, detailed and thorough and this was then reflected in the delivery of the therapeutic activity. Included in the continuation notes was detailed, documented evidence of both pharmacy and physiotherapy interventions and their respective input to their care and treatment.

Although we found risk assessments identified historical and current risks, some risk management plans were blank. Additionally, we noted identified risks, particularly those associated with the risk of significant violence and aggression, were not included in the care plan and therefore no guidance or direction was provided for staff where this would be expected.

Recommendation 1:
Managers should ensure risk assessments include an individual's identified risks to themselves and others, and that risk management plans include the relevant guidance and direction relating to managing identified risks.

Multidisciplinary team (MDT)
A range of professionals were involved in the provision of care and treatment in the unit. This included psychiatry, a speciality doctor, a six-monthly rotating doctor, one annual rotating registrar, nursing staff, health care support workers (HCSWs) and an ASW. Pharmacy, physiotherapist, OT and a discharge co-ordinator were shared with other acute areas on the Carseview site.

We were aware of the gap in the MDT of a dedicated psychologist in the Carseview Centre and recognise the efforts that had been made to secure funding for recruitment to this post and the existing alternative routes that staff had implemented to provide psychology input to the individuals in Carseview, by using

psychology in-reach from Dundee community general adult psychiatric services. Additionally, in response to the recognised need for psychology input, the Carseview Centre's governance group had widened the availability of psychology in-reach to include the provision of this across all three Tayside HSCPs, with referrals from Carseview now being prioritised.

We were told this approach was at the early stages of a testing period and that the effectiveness of this had not been tested enough. However, despite this we continue to feel that dedicated clinical psychology input to Carseview/IPCU would provide staff with valuable guidance and formulation for individuals with challenging and complex needs and is an area that managers must continue to have as a focus. It was understood that Dundee HSCP currently held the full allocation of funding for psychology services. We recognise funding was previously available to support recruitment for psychology staff however, following two rounds of recruitment, no appointments were made and we were told that the funding was no longer available. We will write to Dundee HSCP to clarify their position on funding for psychology recruitment.

Recommendation 2:
Managers must ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and individual groups. Consideration should also be given by Dundee HSCP to make additional funding available to support the recruitment of dedicated clinical psychology staff.

We heard that MDT meetings were held twice weekly with an open invitation for individuals and their carers to attend. Medical staff contacted carers by telephone to provide updates if they were unable to attend the MDT meeting.

We found the documents for the MDT meeting were well-structured, included the individuals' views and gave a good impression of the discussion that took place. We also saw evidence of future planning and identification of potential barriers to discharge.

We noticed the recorded attendance at the MDT meetings was minimal and regularly attended only by the RMO and a nurse. It would be beneficial for a full MDT approach to be involved in the MDT meetings. We discussed this with senior staff at our end of visit meeting and highlighted our expectation that wherever possible, all members of the MDT should be involved in an individual's care and contribute to MDT meetings. This was accepted, with a view to taking this forward at future meetings.

Use of mental health and incapacity legislation

On the day of the visit, four people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Documentation relating to Mental Health Act was easily found and in order.

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. Only one individual required a consent to treatment certificate (T2) or a certificate authorising treatment (T3) under the Mental Health Act. The T2 certificate in place authorised the required treatment and corresponded with the medication being prescribed. On the day of our visit, this was easy to find, in good order and in both electronic and printed formats.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We wanted to follow up on our previous recommendation regarding promoting and encouraging nomination of the named person role. During our review of the care records, we found discussions with individuals about the named person role had taken place, were documented and migrated from EMIS. These included input from a mental health officer (MHO) however, not all the individuals had these discussions recorded; we were told individuals' participation in these discussions varied. We were pleased to find that the named person role was included and discussed at the MDT meeting.

Rights and restrictions

The IPCU is a locked unit and we were satisfied that this was proportionate in relation to the needs and risk identified for those admitted to the unit. There was a locked door policy in place, and we found evidence in the care records of this being explained to individuals.

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 wanted to follow up on our previous recommendation regarding raising awareness and promotion of advance statements. When reviewing the care records, we saw discussions had taken place about advance statements during one-to-one meetings and MDT meetings; we found one advance statement on file. We were told IPCU staff had had discussions with the community teams for them to continue encouraging and promoting the benefits of having an advance statement.

Activity and occupation

The IPCU had input from a dedicated ASW who provided a variety of activities for individuals. We were told the ASW met with individuals to provide them with information on the activities that were available and to gather ideas on their areas of interest to focus on when providing person-centred activities.

We found a good range of activities on offer, which were displayed on the activity board and detailed in an activity booklet. These focused on preparing individuals for discharge, to maximise their independence and increase engagement with staff.

We heard that activities took place on a one-to-one basis or in a group however, we were told the IPCU environment was more tailored to support one-to-one activity. The ASW also worked in collaboration with OT to support some individuals to attend community resources, including an off-site garden group and local swimming pool.

The physical environment

The layout of the unit consisted of individual side rooms that were split into male and female sides with one ensuite bedroom on each side. For males admitted to the IPCU, they had access to two shared toilets and two shared shower rooms, and female admissions there was one shared toilet and one shared shower room.

There were two TV rooms that could be used for mixed or single-sex requirements and a large recreational area that had a pool table, dartboard, gym equipment and an arcade machine. There was also a visiting room that could be used as a quiet room and the ASW had their own dedicated room to provide activities.

The IPCU's garden area had been transformed into a space for individuals and staff to enjoy. The ASW undertook a garden project with the help of individuals to upgrade the garden area with flowers, plants, increased seating space and decorative and recreational elements.

Summary of recommendations

Recommendation 1:

Managers should ensure risk assessments include an individual's identified risks to themselves and others, and that risk management plans include the relevant guidance and direction relating to managing identified risks.

Recommendation 2:

Managers must ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and individual groups. Consideration should also be given by Dundee HSCP to make additional funding available to support the recruitment of dedicated clinical psychology staff.

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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