Mental Welfare Commission for Scotland

Report on announced visit to:
Rohallion Secure Care Clinic, Lyon Ward, Muirhall Road, Perth, PH2 3PT

Date of visit: 06 February 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

Lyon is a 12-bedded, low secure forensic ward that provides rehabilitation and recovery for adult males.

On the day of our visit, there were 12 people on the ward and no vacant beds.

Lyon is based at Rohallion Secure Care Clinic. Individuals admitted to this ward are primarily from the Tayside area.

We last visited this service in October 2023 on an announced visit and made recommendations that clinical information be primarily stored on the electronic record system EMIS (this has since transferred to the electronic system, MORSE) to reduce the risks associated with having two separate recording systems and that any hard copies of key information be current.

We made a recommendation that care plans were person-centred, detailing each individual's identified needs, with interventions in place and that they should evidence each individual's participation, that these were regularly reviewed and their quality audited.

We recommended that an audit be undertaken to ensure that all restrictions were required, proportionate and legally authorised under specified person's legislation and that there was evidence of regular review, with consideration given to appoint a dedicated activity co-ordinator to Lyon Ward to support the continuation and expansion of the good practice of offering person-centred activities to individuals.

The response we received from the service was that an exercise was undertaken to remove duplicated hard copies from the ward, that relevant hard copies of historical clinical information were archived, while each individual's legal documents remained in hardcopy format in the ward in case online services became inaccessible.

We were advised that routine audits took place, that care plans were adapted to meet the standards in the NHS Tayside person-centred care planning format and an audit took place to ensure that all restrictions that were required were proportionate, legally authorised and regularly reviewed and that reasoned opinions were documented in care records and also provided in writing to the individuals where appropriate.

We were also told that any changes to restrictions were agreed at the multidisciplinary team (MDT) meeting and recorded in the individuals care records, that individuals were involved in these and advocacy support was offered.

We were told that although the appointment of a dedicated activity support worker (ASW) was explored, this post had not been appointed to Lyon Ward, however we

were told person-centred activities were offered to individuals on a daily basis; these were displayed on a whiteboard in the ward.

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

Who we met with

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

We spoke with the head of nursing for low secure, both charge nurses, the general manager, and the acting nurse director.

Commission visitors

Gordon McNelis, nursing officer

Audrey Graham, social work officer

Ines Kohls, student nurse

What people told us and what we found

We met with several individuals on the day of our visit who gave us generally positive feedback about staff. We were told staff were “approachable”, “helpful and supportive”, and that relationships between individuals and staff were positive.

Several individuals told us they enjoyed the activities on the ward and valued the IT sessions. The feedback we heard identified a positive theme regarding the patients’ forum, with individuals describing this as “beneficial” and that they enjoyed participating in this.

An individual residing in the pre-discharge flat told us they were happy with the level of independence and responsibility that the environment provided and spoke positively about sharing the living space with others. We were also told that staff accommodated family visits and individuals described the ward atmosphere as supportive, with reports that most individuals were able to have a good level of engagement with staff and felt their points of view were listened to and respected.

However, we also heard contrasting comments from individuals who although they expressed some dissatisfaction with their care and treatment, they described it as “alright”. They told us they had a reasonable relationship with staff and acknowledged that their views were listened to. The individuals we spoke with had an awareness of advocacy services and how to request meeting them.

Care, treatment, support, and participation

Information on individuals care and treatment was held electronically on the MORSE system. During our review of continuation records, we found the nursing notes to be brief with a limited clinical description of each individual’s mental state. We also found that the pre-discharge notes had minimal recorded information relating to each individuals’ mental health and whether they were stable, deteriorating or fluctuating. This made it difficult to identify how the ongoing assessment supported the preparation and readiness for potential discharge from the ward.

In contrast, the nursing summary in the clinical team meeting (CTM) forms recorded a detailed clinical analysis of the individuals mental state, presentation and behaviours.

We raised this with senior staff at our visit feedback meeting and advised that the same level of clinical detail found in the CTM forms should be applied consistently across all individuals’ documentation.

We wanted to follow up on our previous recommendation regarding care plans being person-centred and including evidence of individuals participating in developing these. For this visit, our review of the care plans found them to be person-centred

and they included a broad range of identified needs, clear goals and interventions that focused on the individual.

The care plans connected with the risks and areas of need that had been identified from the risk and admission assessments and provided clear guidance for staff.

It was clear that individuals had contributed to their care plans, as the person-centred information reflected their preferences. We noted care plans were regularly reviewed and audited which gave clear evidence of maintaining the standards in the NHS Tayside person-centred care planning format.

We were pleased to note the visible improvement in care planning across Lyon Ward.

Multidisciplinary team (MDT)
The MDT in Lyon ward consists of psychiatry, nursing staff, occupational therapy (OT), a psychologist and a cognitive behavioural therapy (CBT) therapist.

At the time of our visit, the ward had a senior charge nurse (SCN) vacancy which had been advertised with pending recruitment to the post. The ward had input from pharmacy, dietetics, a discharge coordinator, a practice development nurse and a patient carer lead which were all shared with other areas on the Rohallion site.

Lyon Ward also received support from NHS Tayside community services and input from physiotherapy and a general practitioner (GP).

Rohallion had good links with local services, including support from advocacy, who attended the ward routinely and were available to individuals and carers upon request. There was welfare and financial support from Perth and Kinross' health and social care partnership's (HSCP) allocated social worker. We were told they had established a good relationship with the clinic and supported individuals to apply for, and access funds and benefits.

We were told the MDT meetings were held fortnightly and had 'an open door' approach for individuals to attend.

MDT meeting records showed individuals attending the meeting routinely, and we heard positive feedback from individuals indicating that they valued participating in this meeting.

The MDT meeting records showed representation of the full MDT, including both on site and from external services, however we found these documents were not utilised well and not fully completed.

We noted the nursing staff provided a comprehensive update and summary of the individuals since the previous meeting. However, updates from other disciplines had not been included in the document. We raised this with senior staff at our end of day

meeting and highlighted the importance for all disciplines involved in the individuals care, treatment and support to provide an update for discussion at the MDT meetings.

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).

Information about each individual's rights and restrictions in the low secure environment were provided in an admission leaflet. This was also discussed further during one-to-one discussions with individuals, their named nurse and responsible medical officer (RMO) reviews. We were also told that easy read guidance was available to support the sharing of this information, where appropriate.

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 wanted to follow up on our previous recommendation regarding all clinical documents being primarily stored electronically to reduce the risks associated with having two separate recording systems, and that any hard copies of key information were current.

We found printed copies of all T2 and T3 certificates in good order and all certificates corresponded with the prescribed psychotropic treatment. However, three discrepancies were identified on the MORSE system where electronic copies had not been consistently duplicated, despite valid hard copy certificates being in place. We raised this with senior staff at our end of day visit and advised the storage of both printed and online legal documents must be organised to include up to date versions and for both formats to consistently corresponded with each other.

Recommendation 1:
Managers must ensure that all electronic and hard copy storage of consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act are checked to ensure all certificates are current, correspond with each other and that these storage systems are regularly maintained.

Rights and restrictions

As a forensic low secure ward, Lyon continues to operate with a locked door which is proportionate with 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 all individuals were assigned specified persons status.

On the day of our visit, we wanted to follow up on the previous recommendation that all restrictions are required, proportionate and legally authorised under specified persons legislation and that there is evidence of regular review. We found evidence of discussions taking place between the RMO and the individual to explain the restrictions.

We were told that the ongoing review of restrictions formed part of routine clinical governance processes in the ward and that any changes to restrictions were agreed through the MDT meeting and recorded in each individual's records. We also heard that individuals were involved in discussions regarding restrictions wherever possible and that advocacy support was offered at that time. The feedback we heard from individuals was that they were aware of their rights and the restrictions placed on them under specified persons legislation.

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. Advance statements were promoted well by the ward and easily found on MORSE. We were told that these were explored with individuals during admission and where declined, individuals were regularly encouraged by their named nurse to consider developing one.

Advance statements were also promoted during CPA (care programme approach) meetings.

Activity and occupation

On the day of our visit, we wanted to follow up on the previous recommendation regarding a dedicated activity co-ordinator being recruited to Lyon Ward to support the continuation and expansion of the good practice of offering person-centred activities to individuals.

We were told that possible opportunities to develop an activity support worker role were explored however, cost implications of adding to the workforce had contributed to no dedicated activity co-ordinator being appointed to the ward.

We were told the Lyon Ward MDT, together with Rohallion's dedicated OT team, had explored ways to provide person-centred activities for individuals by incorporating

goal focused activities that reflected the individual's identified needs and preferences.

These were added to personalised weekly planners based on their interests.

Activities were offered daily and included on a whiteboard in the communal area of the ward, detailing what activity was being offered and when. These included relaxation groups, therapet visits to the ward, craft work groups, therapy kitchen sessions, education groups, quizzes, ward based IT sessions, ward-based gym sessions, community outings and pool tournaments.

These were delivered and facilitated by OT staff and health care support workers (HCSWs). We were told there was an evening matrix of available therapy rooms for the individuals to use out with standard working hours, of which the nursing staff group supported them to attend in the evenings and weekends.

The ward also provided links to 'chatterbox' befriending service. We heard consistently positive feedback from individuals who felt that staff encouraged participation in meaningful activities.

From our observation, independence was promoted throughout the ward by enabling the individuals to exercise their choice and take an active role in deciding which activities they preferred. The provision of these activities appeared to reflect a collaborative approach between staff and individuals which contributed towards a sense of community and development of positive relationships through the regular engagement that took place during the activities provided.

The physical environment

The ward was bright and open and consisted of single en-suite bedrooms in the main corridor and two separate bedrooms in the adjacent shared living space 'ward flat' that had shared kitchen and bathroom facilities. This was intended for individuals to develop independent living skills during their rehabilitation phase in preparation for discharge from the ward.

The ward had access to a communal courtyard, TV room, open kitchen, laundry room and pool table in the communal area.

We were informed that the Rohallion estates service undertook regular walk rounds across the service to identify environmental and maintenance issues. Identified issues were reviewed every four weeks, with contingency plans arranged to facilitate required estates work while minimising disruption to the ward.

We were also told that health and safety and healthcare associated infection (HAI) teams closely monitored any issues that were raised to ensure that these were appropriately addressed in a timely manner. During our tour of the ward, we noted

what appeared to be mould issues in some areas, although these were not accessed by individuals receiving care. We were told that although this had been identified by estates, who planned for anti-mould paint to be applied to these areas, this process had been delayed.

Recommendation 2:
Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as is practicable.

Summary of recommendations

Recommendation 1:
Managers must ensure that all electronic and hard copy storage of consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act are checked to ensure all certificates are current, correspond with each other and that these storage systems are regularly maintained.

Recommendation 2:
Managers should ensure that outstanding repair and refurbishment work is 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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