

Mental Welfare Commission for Scotland

Report on announced visit to:

Carseview Centre, Ward 1, 4 Tom MacDonald Avenue, Dundee,
DD2 1NH

Date of visit: 17 March 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

Ward 1 is a 22-bedded, mixed-sex, general adult psychiatric acute admission ward. Ward 1 is based at the Carseview Centre. Individuals admitted to this ward are primarily from the Dundee area of Tayside, but admissions can also come from Perth and Kinross and the Angus areas. On the day of our visit, there were 17 people on the ward and five vacant beds.

We last visited this service in November 2024 on an announced visit and made recommendations around compliance with no smoking legislation and to promote the provision of a safe, pleasant and therapeutic environment for all; that there was dedicated clinical psychology input to the ward to support the development of psychological therapies and interventions across the staff and individual groups; that the multidisciplinary team (MDT) ensure that all psychotropic medication was legally and appropriately authorised and that an audit system was put in place to ensure compliance; that where a person lacked capacity to consent to any intervention, the appropriate legal framework was utilised where required, and that an audit system put in place to ensure compliance with this; that consideration was given to the use of space in Ward 1 to ensure therapeutic spaces were available to support and enhance individual wellbeing and that confidentiality of sensitive information was upheld.

The response we received from the service was that a paper had been drafted outlining the issues with non-smoking compliance and the associated risks to the service. New signage had been put in place across wards and non-compliance issues were being shared with other health boards, including community colleagues for input. We were informed that there was input from a psychology in-reach pathway to Ward 1 from community services to provide assessment and formulation to cases that would benefit from this input.

Ward 1 now had pharmacy staff carrying out three monthly audits and that mental health act administrators sent reminders and alerts to consultants when T2 and T3 certificates were required.

We were advised that information on the individuals who lacked capacity to consent were included in the MDT review sheet, discussed at the rapid run-down meeting and also added to the "at a glance board" in the nursing office.

Ward 1's therapeutic spaces were no longer used for meetings and an additional privacy film had been applied to cover confidential information in the office area and discussions were ongoing about the potential solution for confidential information to be stored digitally.

On the day of this visit, we wanted to follow up on the previous recommendations and speak with people receiving care and treatment on Ward 1.

Who we met with

We met with, and reviewed the care of 11 people, seven of whom we met with in person and reviewed four sets of care records. We also met with three members of staff and spoke with the senior nurse, the senior charge nurse, and met with advocacy.

Commission visitors

Gordon McNelis, nursing officer

Denise McLellan, nursing officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

During our visit, we spoke with several individuals who were generally positive with their feedback about the staff and the care they received. Staff were described as “really nice”, professional, “fair” and “respectful”. Several people highlighted the positive relationship they had developed with staff, with one individual commenting “I can’t fault it here, there’s a great bunch of staff”. Others said that staff would “go that wee bit extra” when support was needed. Individuals told us they felt safe and comfortable on the ward and described it as a “good ward”.

Individuals also shared comments where they felt improvements could be made. We heard from a small number of people that MDT meetings could feel intimidating and described feeling “stared at” during discussions. We heard that information provided was not always presented in a way that was understandable and they suggested more easy-read versions of information would be helpful. We also heard that individuals would value greater access to counselling or psychology services.

Staff spoke positively about working on the ward and described a supportive team culture. We had staff tell us “I love my job”, while another described the team as working well together and being able to manage a wide range of situations effectively.

On the day of our visit, we found the ward had a supportive and positive atmosphere and we observed staff who helping to meet the requests from individuals in Ward 1.

Care, treatment, support, and participation

Information on individuals care and treatment was held electronically on the MORSE system.

During our review of care plans we found these were person-centred, robust and they provided a clear understanding of the individuals’ current and historical circumstances and care needs. Interventions were clearly documented and easy to follow.

During our discussions with people, it was clear that some of them were not aware of their care plans, whereas others had a copy and spoke about being involved in developing these. During our review of the continuation records, we noted how engagement and discussion took place and it was documented where nursing staff approached individuals to discuss their care plans.

As part of the admission process, we found copies of pharmacy care plans and holistic mental health assessments that identified risks and care needs which contributed to treatment and support. Five care plans were audited per month, with findings shared through feedback with staff. We were told link care plan workers held workshops around improving care plans and carer involvement as part of Ward

1's 'Triangle of 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.

Care records

During our review of continuation notes, we found the nursing entries were detailed and descriptive and gave the reader a good understanding of the individual's presentation, structure and activity.

Risk assessments were person-centred and presented in a structured format that clearly identified current and historical risks. Staff comments and additional information associated with these were thorough, informative and gave the reader a good understanding of the risks. We found information gathered from carers and external services which gave a coordinated approach to managing risks, which provided the appropriate care, treatment and support. We found risk management plans responded to identified risks and provided good guidance, with actions to be taken in certain scenarios, however we found some of these to be more detailed than others.

We saw documented evidence of routine one-to-one discussions taking place between individuals and nursing staff. We found these to be descriptive, meaningful and they captured the views of the individual.

We saw informative reports in the Responsible Medical Officer's (RMO) consultant medical reviews. These were robust, included descriptive historical and current content, including treatment plans, and where appropriate, consultation with family members prior to the review.

Admission documentation was robust and provided the reader with an understanding of the individual's situation and circumstances. As part of the admission process, we were told about the additional implementation of the new alcohol, smoking and substance involvement screening tool (ASSIST) questionnaire that had been developed in association with the service's substance misuse liaison worker.

Multidisciplinary team (MDT)

The MDT for Ward 1 consisted of nursing staff, consultant psychiatrist, locum consultant psychiatrist, learning disability (LD) consultant psychiatrist, resident doctors, physiotherapist, occupational therapist (OT), pharmacist, activity support worker (ASW), dietician, discharge co-ordinator, Angus Health and Social Care Partnership (HSCP) discharge social work team and a substance misuse liaison worker.

We were told the MDT meeting took place twice per week and the rapid run-down meeting took place weekly. The MDT meeting template recorded those who

attended and included information from external services and feedback from carers and welfare guardians. We found discussion summaries gave the reader an understanding of the individual's situation, the MDT actions and included plans for progress, where appropriate.

Carer engagement was encouraged through the triangle of care model, and carers were invited to all MDT meetings with their views contributing towards individuals' care plans.

We were told about a new full-time substance misuse liaison worker had been in post for the past six months and covered the Tayside area. They had input at rapid run-down meetings and they provided support to individuals through one-to-one interaction; they also gave advice on medication guidance.

On the day of the visit, we wanted to follow up on our previous recommendation regarding the gap in the MDT of dedicated psychology input. We were advised of the current referral process and that the community psychology in-reach service remained in place providing support and beneficial formulation plans to address individual's complex needs. In addition to this, a review of psychology referrals was planned, with consideration for formulation training for staff to support this ongoing gap in the MDT. While we were pleased to hear there had been some progress, we consider that it is important that further progress is made, due to the comments we heard from individuals in the ward about the value placed on this.

Recommendation 1:

Managers should ensure progression of their plans to achieve dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and individual groups.

Use of mental health and incapacity legislation

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

On the day of the visit, we wanted to follow up on our previous recommendation regarding all psychotropic medication being legally and appropriately authorised and an audit system be put in place to ensure compliance with Part 16 of the Mental Health Act, which 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.

We were told the previous consent to treatment certificate (T2) and certificates authorising treatment (T3) under the Mental Health Act audit process had been reviewed by a pharmacist-led short life working group. This review resulted in the

introduction of three-monthly pharmacy audits, input from the Mental Health Act administrator to provide alerts and reminders to consultants about T2 and T3 certificates, and for these expiry dates to be added to the information board in the nursing office to support ongoing oversight. We were pleased to find that consent to treatment certificates and certificates authorising treatment under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

We also wanted to follow up on our previous recommendation regarding the appropriate legal framework being utilised where a person lacks capacity.

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 (the 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.

Although there were no individuals in Ward 1 who were subject to a section 47 certificate at the time of our visit, staff advised that individuals who lacked capacity, or who required welfare or financial guardianship were identified and discussed during MDT and rapid run-down meetings, as well as through liaison with social work colleagues. If an individual lacked capacity, this was included on the nursing “at a glance” board and documented in the person’s care plans.

Rights and restrictions

A locked door policy remains in place for Ward 1. We were satisfied that this was proportionate in relation to the needs for most of the individuals in the ward. The locked door policy continued to be reviewed daily and at the rapid run down meetings.

At the entrance to Ward 1 we saw appropriate use of QR code signage advising visitors and individuals of the locked door policy restrictions in place. The locked door policy was explained to individuals and their carers as part of the admission process. We found evidence that these discussions had taken place recorded in the care records. Some individuals mentioned they had a good understanding of the ward’s locked door policy and of the process to follow when requesting time out from the ward.

Most of the individuals we met were aware of, and had a good understanding of their rights. We were told that these had been explained to them at the time of admission and revisited throughout their inpatient stay during MDT meetings and medical reviews.

We were told individuals had access to advocacy for support and that referrals were normally completed by the mental health officer (MHO) as standard practise during the admission process.

Activity and occupation

Ward 1 had input from a dedicated ASW, OT and physiotherapist who provided a variety of person-centred activities. We heard that the interests and preferences of individuals were gathered during weekly meetings with them and then added to a tailored activity planner. These included arts and crafts, board games, exercise groups, music groups, playing pool and relaxation groups.

We heard that the ward takes part in the event “wellbeing Wednesday”; this occurs once a month, with the other four wards in Carseview and focuses on therapeutic activities. This was well attended by individuals and staff. We heard positive comments from individuals about the range of available activities and they gave praise to staff for their input.

The physical environment

The layout of the ward consists of single en-suite bedrooms, a large sitting room and smaller sitting room, which at the time of our visit, was being used as a gym. The ward also had an art room and access to a garden area with both being used regularly by individuals.

On the day of our visit, we wanted to follow up on our previous recommendation regarding compliance with the no smoking legislation and to promote the provision of a safe, pleasant and therapeutic environment for all. In response to this, we were advised a paper had been drafted for the Health and Safety Committee and Partnership Forum outlining the issues of compliance and the associated risks. New signage on the no smoking policy was displayed throughout the ward, and the general manager was also seeking support from community colleagues for them to offer help in support individuals to stop smoking.

During our observation of the garden area, we saw individuals smoking at the entrance. We raised this during our feedback meeting, where the ongoing difficulties of implementing the no smoking legislation were acknowledged. We discussed progress made since the implementation of our previous visit action plan from February 2025. This included senior management liaising with other NHS services to look at ways to implement the smoke free legislation. A questionnaire developed to gather individual’s views which identified smoking as an ongoing challenge. This issue remained red on the service’s risk assessment and continued to be discussed at senior level. We shared information on different approaches taken by other health boards to manage the no smoking legislation, which included changing the use of

the garden areas as a health and wellbeing space and having an MDT approach that reinforced the no-smoking message.

Staff also reported increased verbal and physical aggression when reinforcing the no smoking policy which had a significant negative impact on staff wellbeing. We were advised a small team had been established to explore the issue further. We acknowledge the challenges associated with enforcing the no smoking legislation but were disappointed with the minimal progress around this.

We were concerned that despite legislation being in place for a number of years, NHS Tayside still has individuals who breach this and who smoke in the hospital garden and grounds, which has a detrimental effect on people's physical health. We are therefore repeating our previous recommendation and will continue to follow this up with senior managers.

Recommendation 2:

Managers must ensure compliance with the [Smoking, Health and Social Care \(Scotland\) Act 2005 \(part 1\)](#) to promote the provision of a safe, pleasant, and therapeutic environment for all and must ensure that staff are given support to manage this.

We followed up on our previous recommendation regarding the availability and use of space for therapeutic activities and were pleased to hear that the therapeutic spaces were no longer used for team meetings, with alternative spaces being used instead.

Lastly, we followed up on our previous recommendation regarding the confidentiality of sensitive information. We were told that alternative solutions to storing confidential information had been explored with consideration for this to be stored digitally. Additionally, we were told that an additional privacy screen had been fitted to the window area of the nursing office.

Summary of recommendations

Recommendation 1:

Managers should ensure progression of their plans to achieve dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and individual groups.

Recommendation 2:

Managers must ensure compliance with the [Smoking, Health and Social Care \(Scotland\) Act 2005 \(part 1\)](#) to promote the provision of a safe, pleasant, and therapeutic environment for all and must ensure that staff are given support to manage 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 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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