

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Murray Royal Hospital, Leven Ward, Muirhall Road, Perth PH2 7BH

Date of visit: 14 July 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

Leven Ward is a 14-bedded, mixed-sex, admission assessment ward for older adults, over the age of 65 who are experiencing acute mental illness. On the day of our visit, there were 14 people on the ward. Two individuals were delayed from being discharged from the ward as they were awaiting a care home placement and suitable housing.

Leven Ward provides care for individuals primarily from the Perth and Kinross area. On the day of the visit there was one individual who was boarding from another area.

We last visited this service in May 2025 on an announced visit and made no recommendations.

On the day of this unannounced visit, we wanted to meet with individuals and speak with their relatives. We wanted to ensure that care and treatment was being provided in line with mental health legislation and in a human rights compliant model.

Since our last visit we had been made aware of one significant incident, and we were aware that the service had carried out a significant adverse event review (SAER) following this.

We were informed since our last visit there was a new senior charge (SCN) and charge nurse (CN) in post. We were informed that there were a few nursing vacancies in the ward, although there were plans in place to recruit to these.

Who we met with

We met with and reviewed the care of six people. We also met with two relatives.

We spoke with the charge nurse, consultant psychiatrist, psychologist, clinical and professional team manager, acting nurse director, activity support worker (ASW) and nursing staff.

Commission visitors

Justin McNicholl, social work officer

Susan Hynes, nursing officer

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included contact with staff, participation in their care and treatment, activities that were available to them and their views of the environment. We were also keen to review the plans for individuals who had been in the wards for a considerable period of time and those who were experiencing their first admission to a mental health service.

The longest admission to the ward had been for eight months, with most individuals experiencing short admissions to the ward of on average, one to two months. There were five individuals who were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) with the rest being informal admissions. We found no individuals who were subject to continuous interventions.

All individuals and relatives that we met with praised the care and treatment being delivered by the staff in Leven Ward. We were told all staff were, "very good", "excellent", "exceptional", absolutely fantastic" and "really good". One individual stated, "this is the best ward I have ever been in". There was significant praise for the hard work, dedication and inventive practice of the ASW in providing a variety of meaningful activities that helped individuals pass the time. One individual commented, "she is wonderful, I am never bored and there is always something going on". We observed this taking place throughout the day of our visit, with various steps taken to engage and motivate individuals to participate in the various activities on offer.

All individuals supplied positive feedback regarding the ward environment, noting it as "excellent", "lovely" and "ideal".

We discussed with individuals how they were supported during the early stages of their admission. Some individuals, due to how unwell they were at this time could not recall the admission process. Others commented; "I was made to feel welcome right away" and "they helped me settled in".

We had sight of the ward "You Said, We Did" approach which captured plans for the ward to introduce an information leaflet to aid individuals and their relatives/carers to understand how the ward worked. We received several comments that individuals felt safe and they were able to approach staff at any time day or night with questions and that they could seek reassurance or support.

Individuals praised the doctors, advising "the psychiatrist is really good, I see her regularly" and "I meet with her at least once a week if not more". We heard positive feedback on the work of the psychology staff, with one individual stated, "psychology is a great asset to the ward, we need more of them in the hospital and the community as they are invaluable". We heard similar themes from individuals highlighting the impact this area of work was having on their lives and recovery.

Most individuals we spoke with said the food was “good”, “excellent” and “there is a great variety of options and if you don’t like something they will make you something else, they are very accommodating”. One individual spoke of the food being “eatable”.

We heard from relatives and friends who praised the staff. One stated, “I can’t see any fault with the ward or the staff, they seem to like him and are good with him”. We heard from one relative whose family member had experienced some initial issues with a member of staff. They spoke of how these issues had been addressed and they found a significant improvement in how their relative was being treated. One relative stated, “they are very kind, compassionate and know him well, they want to help”. Relatives acknowledged the dedication of the activity support worker, but we picked up a consistent theme regarding the lack of group work available in the ward. They spoke of how therapeutic groups would support a meaningful recovery and could work in tandem with medication to ensure sustained improvements.

Recommendation 1:

Managers should seek to address the lack of therapeutic group work available to individuals on the ward.

Care, treatment, support, and participation

We reviewed some of the care records for those in Leven Ward. NHS Tayside has adopted the MORSE electronic record system for use in Murray Royal Hospital, with this going ‘live’ in the last year.

We reviewed care plans, risk assessments and risk management plans. We discussed and considered the value and the need to capture the individual’s social history. During the visit we found ‘Getting to know me’ documentation recorded in the individual paper record as well as on MORSE. The information from this document, and relevant life history information was also documented in the initial assessments.

We reviewed the ward initial assessments and risk assessments. We found these to be person-centred. The information recorded in these forms helped to inform the care plans which were thereafter reviewed and updated to reflect any changes in the needs of the individual and the care being delivered by staff.

We found care plans to be completed to a good standard with a clear focus on mental health and physical wellbeing. We noted that there were two types of risk assessment held on MORSE which captured the risks that individuals may pose to themselves or others. These were the mental health/learning disability holistic mental health risk assessment and a separate risk assessment and management plan. There were plans to streamline these documents in the coming year which will

result in one single risk assessment. We look forward to seeing how this progresses on future visits.

Care records

Every individual had an electronic MORSE record and a brief paper record. From reviewing the care records, we found MORSE to be intuitive and easy to navigate. Templates had been created to ensure that accurate information was captured during every meeting, which supported cross-team communication. There was evidence that psychology, psychiatry, nursing, occupational therapy (OT) and ASW input was recorded on a consistent basis. This co-location of all information helped to aid care planning and any planned intervention delivered by a member of the team.

The recordings were found to be individualised and meaningful. We found individuals had clear one-to-one discussions recorded with staff. Most entries provided a good description of the individual's current mental state and their views about their treatment. We noted that the ward employed Band 4 health care support workers who played a significant role in delivering care and recording aspects of care and treatment.

There were some gaps in the views of family members or carers being taken into consideration to deliver the best outcome for the individual. We did not find any significant evidence that family members views were being consistently recorded in the individual notes. The recording of any relative's views appeared to be occurring on an ad hoc basis. This was reflected in the views shared by the relatives that we spoke with. We have seen good evidence of this working well in practice across Scotland in various services, but it was lacking in the care records we reviewed.

Recommendation 2:

Managers should review their processes to improve the recording of relatives and carers views and ensure these are fully integrated to deliver the best outcomes for individuals.

Care plans

Care plans are a tool that identify detailed plans of nursing care and intervention; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

We found that individuals in the ward had care plans in place which were meaningful, personalised, up to date and reviewed regularly. Some of the review information was at times basic but it was sufficient to ensure that there was a clear understanding of progress towards any identified outcomes. We found each care plan had clear interventions and actions. We found that the one-to-one meetings between individuals and their named nurse, clearly linked with the care plans. We found

overall that the staff were using these recordings in a meaningful way. The care plans ensured that both mental health and physical health were considered and framed in a way that demonstrated that input by various professionals was making a clear difference to the individual.

Multidisciplinary team (MDT)

A range of professionals were involved in the provision of care and treatment of individuals in the ward. This included psychiatry, psychology, junior doctors, all grades of nursing staff, OT, physiotherapy, pharmacy, a transitional care nurse (TCN), an ASW, mental health officers (MHOs) and social workers (SWs).

We asked relatives and carers if they, or their relatives were invited to the multidisciplinary team (MDT) meetings which occurred each Monday on the ward. It was confirmed that neither party were invited but despite this, the medical and nursing staff were always available to communicate updates to them each week.

We heard from staff that the ward was going through a natural transition of change due to new nursing management. We received positive feedback on these changes.

Medical staff highlighted that there was a gap in the number of core medical trainees on placement to the ward. We met with one of psychologists who presented as enthusiastic and keen to deliver positive outcomes for individuals. We heard about the lack of dedicated funding of psychology staff to the ward. We raised the short fall in medical trainees and psychology staff with managers at the end of day and they agreed to look into addressing these matters.

Recommendation 3:

Managers should seek to ensure that there is sufficient access to funding medical trainees and psychology staff to support individuals in the ward.

We were told that the ward held a weekly MDT meeting, and we were advised that everyone's care and treatment was discussed at this meeting. We noted the positive impact of having dedicated social work and TCN input to the ward which supported effective discharge planning.

There was a record of who attended the MDT. We noted that no individuals were invited to the MDT. It was confirmed that individuals were met with before and after the meeting to supply updates on any decision taken.

The MDT meeting record was not always located in the MORSE daily notes and some were held in a separate document tab. We would hope that recording will become more consistent as the new system embeds over the coming year. The MDT meeting records we viewed were comprehensive and provided an evaluation of each individual's progress. We saw care and treatment plans being adjusted following reviews, to support any areas of progress or elements of increased support needed.

There were two psychiatrists who covered the ward and who had responsibility for determining admissions. We met with the lead psychiatrist to discuss the ward function. We asked about the two individuals whose discharges had been delayed. We were told that there were challenges with the provision of suitable accommodation for both individuals to move on to when ready for discharge. We will continue to follow these cases up with senior managers.

Use of mental health and incapacity legislation

On the day of the visit, five people were detained under the Mental Health Act.

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.

On reviewing the records, we found the electronic medications Kardex records were stored on the hospital electronic prescribing and medicines administration (HEPMA) system.

Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place, however we found one which did not correspond to the medication being prescribed. We raised this with the responsible medical officer who agreed to take steps to address the treatment being delivered.

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (AWI Act), including certificates around capacity to consent to treatment were found on file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

We reviewed section 47 certificates and found that no legal proxy or key decision makers had been consulted in relation to completion of section 47 certificates, which is a requirement of the AWI Act. We saw that some section 47 certificates referred to the use of prevention and management of violence and aggression (PMVA) strategies. The Commission advises that any strategies to manage violence and aggression of incapacitated adults must be clearly authorised and section 47 certificate do not confer the authority for this. This was shared with the medical staff on the day who agreed to review this and consider the use of the Mental Health Act or other sections of the AWIA for those involved.

Recommendation 4:

Managers should ensure that all section 47 certificates are reviewed to remove the authorisation of prevention and management of violence and aggression (PMVA).

Recommendation 5:

Managers should ensure that if an individual has a welfare proxy with the power to consent to medical treatment, then their consent should be sought when completing section 47 certificates.

Anyone who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had not nominated a named person, we were told nursing staff, MHOs and advocacy encouraged individuals to appoint one and promoted the importance and benefits of this.

We understand that sometimes people are too mentally unwell and not able to fully consider this, but we were told that this was revisited when people's mental state improved.

Rights and restrictions

A locked door policy could be utilised in Leven Ward to provide a safe environment and support the personal safety of individuals. We were informed that the need to lock the front door of the ward was reviewed daily and the door was locked on the day of our visit.

From the Commission perspective this measure appeared proportionate. For individuals who were admitted to the ward informally and who did not need the door locked, we saw evidence of timeout plans, which had been agreed by the person. We found evidence that individuals were made aware of the locked door arrangements and that they consented to these at the time of their admission. This was confirmed when we spoke with individuals and in the records we reviewed.

While reviewing care records, 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 were told staff encouraged individuals to have an advance statement by promoting them during the individual's recovery and discharge planning. Reminders were also included in the ward discharge checklist document and community mental health teams were encouraged to follow them up with individuals following discharge. However, despite these efforts, we found no advance statements in the records.

We were told advocacy visited the ward, and access was available by self-referral or by ward staff identifying a need and then encouraging and supporting the individual to arrange contact with them. We heard directly from those subject to the Mental Health Act that they had met with advocacy and had a clear oversight and understanding of their role.

We spoke with one individual whose views on being admitted to the ward informally were variable and they spoke of their wish to return home. We raised this matter with the consultant psychiatrist and nursing staff on the day, and they intended to ensure that the individual's informal status on the ward was reviewed to ensure this remained appropriate. We heard from one individual who spoke of their relative being denied access to advocacy while being informally admitted. We raised this with managers as this approach did not appear to be proportionate, reasonable or inclusive. The ward staff confirmed that an immediate referral to advocacy services would be made to ensure that the individual's rights were upheld.

The Commission has developed [Rights in Mind](#). This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

Activity and occupation

We found Leven Ward to have extensive input from a designated ASW who devised a weekly activity timetable, which included input from individuals to identify and focus on their preferences and interests. The activity planner was on display on the ward noticeboard and included a wide range of activity options such as reminiscence, bingo, yoga, music quizzes, table tennis, hairdressing, walking group, gym and gardening.

Similar to our last visit, we were pleased to see that not all activities took place on the ward. OT staff also provided individualised, focused, structured and therapeutic activities that promoted and taught skills that were transferable to outside living. These included using the activities of daily living kitchen, as well as having a focus on improving the physical health of individuals with seated and strengthening exercises.

We were able to observe some of the activities made available, including an arts and craft session which involved painting and felting. The individuals and staff we spoke with were very complimentary about the ASW and positive about the activity and occupation available on the ward. We heard some comments that the weekends could on occasion feel "boring" or "quiet". Despite this, individuals spoke of this being a common occurrence in their own lives at home and this was not dissimilar to the expectation of real life.

We found extensive person-centred activity care plans for everyone which were regularly reviewed and updated.

The physical environment

Leven Ward offers a bright, pleasant environment with individuals accommodated in single rooms, with en-suite facilities and access to an activity room, a television room, lounge and two well maintained gardens. The ward had various tactile tools in place which encouraged interactivity; we were able to observe the individuals using the garden throughout our visit. The ward areas and bedrooms were found to be clean.

Similar to our last visit, Leven Ward was a therapeutic and calming environment for individuals. We were pleased to see various information leaflets and easy-to-read signage throughout the ward, encouraging people to take some gentle exercises during their stay. Leven Ward has continued to utilise 'floor nurses' on each shift which ensures regular contact with individuals and for them to be responsive to any presenting distress or risks.

Summary of recommendations

Recommendation 1:

Managers should seek to address the lack of groupwork available to individuals on the ward which could focus on recovery.

Recommendation 2:

Managers should review their processes to improve the recording of relatives and carers views and ensure these are fully integrated to deliver the best outcomes for individuals.

Recommendation 3:

Managers should seek to ensure that there is sufficient access to funding of medical trainees and psychology staff to support individuals in the ward.

Recommendation 4:

Managers should ensure that all section 47 certificates are reviewed to remove the authorisation of prevention and management of violence and aggression (PMVA).

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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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