

Report on the joint unannounced visit/safe delivery of care inspection

Dudhope Young People's Inpatient Unit

NHS Tayside
October 2025

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Foreword

The Minister for Social Care, Mental Wellbeing and Sport committed to address the serious concerns raised by the BBC documentary (aired in February 2025) regarding the experiences of young people in Skye House in Glasgow. The Minister commissioned the Mental Welfare Commission for Scotland (the Commission) and Healthcare Improvement Scotland to carry out visits/inspections across all three young people units in Scotland and the separate children's in-patient psychiatric unit in Glasgow.

As part of this collaborative approach, Healthcare Improvement Scotland and the Commission committed to ensure that our skills, experience and resources were jointly used to deliver comprehensive, independent and robust assurance of the units.

In October 2025 we visited/inspected the Dudhope Young People's Inpatient Unit, NHS Tayside. Dudhope is a 12 bedded Tier 4 specialist Child and Adolescent Mental Health Inpatient Unit based in Dundee. Child and Adolescent Mental Health Tier 4 services are highly specialised units for young people who require assessment and treatment for complex mental health needs. Dudhope provides a service to children and young people across the area of the North of Scotland. NHS services in Tayside, Highland (excluding Argyll and Bute), Grampian, Western Isles, Orkney and Shetland have access to beds in the unit. However, young people may also be admitted from other regions on an emergency basis if there are no other available beds.

Introduction:

About this visit/inspection

We undertook a joint unannounced visit/inspection to Dudhope Young People's Inpatient Unit from 20 October to 22 October 2025. Two different methodologies were employed and are described in Appendix A.

Whilst the Commission and Healthcare Improvement Scotland's approaches are different, they are also complementary. The context of systems, leadership and governance (the macro level) scrutinised by Healthcare Improvement Scotland has a direct relationship to the experience of those receiving care and treatment (the micro level and statutory focus of the Commission) and vice versa. The aim of this collaboration therefore was to jointly deliver enhanced, independent assurance of the unit.

The Commission and Healthcare Improvement Scotland would like to thank NHS Tayside, all staff in the Dudhope Young People's Inpatient Unit, the young people receiving care and treatment, their families, advocacy staff and mental health officers for engaging in this joint unannounced visit/inspection process.

Experience of care and treatment

What the Commission did

While the Commission's usual approach involves visiting a ward on one day, on this occasion we visited Dudhope over a three-day period in October 2025. There were nine young people receiving care and treatment in the 12 bedded unit throughout our visit. One of the ensuite rooms was not being used due to environmental damage so, in effect, only 11 beds were available during the time we visited/inspected.

The length of stay of the young people in Dudhope Unit ranged from less than one week to approximately 18 months. Five young people were receiving care and treatment on a compulsory basis according to the Mental Health (Care and Treatment) (Scotland) Act 2003. The other four young people were in Dudhope on a voluntary basis.

- Nine health records of the young people were reviewed by Commission staff and double read by a second different Commission mental health professional (that is, each record was reviewed by a nurse and a doctor, by a social worker and a nurse etc).
- We engaged with six young people and eight nursing staff who described themselves as the young people's key workers/named nurses.
- We engaged with the relatives/carers of six young people.
- 15 of the multidisciplinary staff working directly on the unit provided us with information.
- We also received feedback from three mental health officers, and one response was received from the advocacy service working with the young people on the ward at the time of our visit.

Children and Young People

What we expect:

Inpatient Child and Adolescent Mental Health Services (CAMHS) are regarded as Tier 4, that is, they are required to meet the needs of young people with the most complex, severe or persistent mental health problems¹.

We would expect young people receiving services in Dudhope Young People's Inpatient Unit to receive holistic, person-centred care delivered by an experienced, specialist, multidisciplinary team which is inclusive and recognises the young person as a unique individual. We would expect the young person to have a key worker/named nurse with whom they have built or can build a therapeutic and trusting relationship. We would expect young people to be fully aware of their rights, to be treated with dignity and respect and for all interventions to be lawful.

What we heard:

There were nine young people on the unit when we visited; seven of whom had a confirmed diagnosis of mental illness. The children were encouraged to personalise their bedrooms to reflect their interests and preferences, and we saw many examples where this had been

done.

Five of the young people were receiving care on a compulsory basis at the time of our visits whilst four were receiving this voluntarily.

We received feedback from six young people aged between 15 and 16 years.

All of the young people we engaged with said that they had been given enough information about the unit. Some caveated this with the fact that it was not enough to take away the fear of admission and others explained that their previous admissions had helped them to understand what to expect.

We learned that bespoke arrangements were made. For example, photos of staff and of the ward given in advance of admission. Welcome packs, “gentle and soft-spoken staff” and tours of the ward were also said to have helped.

Most of the young people who engaged with us said that subsequent information provided was explained in a way that was easy to understand, including legal status, advocacy, diagnosis, rights and medication. Support from advocacy staff, nurses and the responsible medical officer was said to facilitate this. The role of the mental health officer (MHO) was not mentioned, however. MHOs have a crucial role in supporting individuals and ensuring their rights are protected so there is expectation that this role would have been acknowledged.

“My doctor spoke to me at length about medications and gave me information on side effects and asked my view what medication I would prefer”.

All of the young people who engaged with us understood that they had a named nurse or keyworker and told us their names. Six of the named nurses also engaged with us.

All six of the young people told us that they had a plan of what is going to happen to make them well so they can leave the unit and the majority spoke positively about their inclusion.

“I was always aware of the plan of care and treatment for me and the purpose of the admission which was to make me better and support me to go back home to my family”.

“I have discussions with [keyworker named] and I go to my meetings with everyone. I have seen my care plan and gave information for it”.

“When decisions were being made, I was asked my views and felt these were listened to”.

Another young person, however, spoke about their inconsistent involvement relating to decisions about meal plans.

Four out of five young people who were prescribed medication told us that they understood why they needed it and they were able to tell us about their medicines and rationale for taking them linked to their health conditions.

“Dr ... explained medication to me at length and I was aware of why I needed it”.

Most of the young people we spoke with seemed unsure about what would happen if they refused medication, however.

“Don’t know”.

“I haven’t refused medication before”.

The reported experience of others gave an indication of what happens in practice.

“...some staff would say ‘just take it’. Other staff were more supportive and would explain why it was needed and how it would help me. If I refused, staff would give me time to think about it and would then reoffer me the medication”.

Named nurses also explained that medication may be added to a nasogastric feeding tube (NGT) feed or changed to an alternative format; one person refused capsules so has instead been prescribed oral solution.

Five out of six young people said that staff talk with them regularly about how they are feeling (confirmed in recorded one to one discussions on file). They reported feeling listened to and able to ask staff any questions. Staff were described as “approachable” and “really nice”. None of the feedback included any reference to staff being too busy to engage or some staff being better than others.

“...the nurses are lovely and really nice and they always come and have a chat with you”.

All children and young people reported that staff answer their questions in a way that they can understand.

“they are very good at that”

“Staff always provided a good explanation to me which I was able to understand”.

The privacy afforded to young people when talking about their care and treatment was also said to be “amazing”.

When asked about any restrictions being in place, most young people who responded said that they are able to see their parent or carer when they want to (apart from protected mealtimes or during school time). Two of the young people described other restrictions, one person spoke about not always getting access to their phone or iPad when they wanted to and another said phones were not allowed in school and they were “not that bothered” about it. Named nurses explained that there is a ward mobile telephone policy in place; young people are asked to hand their phones in between 11pm and 10am (they are charged at this time).

Case records highlighted that four out of the nine young people at Dudhope when we visited had been restrained/secluded and/or given urgent medication against their will.

Three young people said they had been restrained at some point during their admission. Two of them said they thought that they had care plans in place for when they are finding things difficult and are struggling but were not entirely sure. One person said that when the care plan was followed “I feel it prevented more restraint”. The three young people also spoke about being given intramuscular medication and whilst this was said to be done in a supportive way and in a private area, one young person wished more time had been given to “de-escalation” to avoid this.

Those who engaged with us did not feel that they were discriminated or treated differently to others. The majority did not like the food on the unit describing it as “not yummy” with “weird textures” and not enough choice.

All six young people told us that they ‘mostly’ have enough things to do in the unit throughout the week/weekends/evenings. Film nights, school, art groups, cards and board games, outdoor trips and the garden were all highlighted. Review of case records confirmed a

range of activities offered to reflect personal choices, preferences and abilities and our observations suggested evidence of an 'activity culture' supported by the occupational therapist. For example, there was a ward activity board, and each young person had their own personalised planner in their bedroom area, which was regularly updated. There was a light, airy gym, well used sensory room and attractive outdoor space.

The young people said it was quiet enough to sleep at nighttime, and they generally felt safe on the unit.

None of the young people on the ward had completed an advance statement (despite some having experienced more than one admission). From discussions with young people and staff and through the review of case records, there appeared to be no consideration or discussion of advance statements. We heard from a senior member of staff that they believed this was the responsibility of community rather than inpatient services.

The young people were asked to rate (on a sliding scale) how well they thought they were looked after on the unit overall. Four people chose to respond to this question. The lowest score was "okay" or satisfied with a couple of other responses higher including one rated as "fantastic".

"My admission has helped me"

Another young person compared their current experience to an admission elsewhere: "This ward is far better than where I was previously... and has helped me to realise that not all inpatient units are as bad".

Carers/Relatives

What we expect:

Section 278 of the Mental Health Act places a duty on the NHS, and local authorities to take steps to mitigate the impact of detention on family relationships. This duty applies where a child is under 18, is detained or when a parent of a child is detained. This is in keeping with article 23 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and respect for home and family life.

We expect therefore that families should always be allowed and encouraged to offer information to professionals involved in a young person's care and treatment. In all situations, and regardless of the young person's consent or capacity, families can give information to the professionals involved and staff should listen to them. Families and carers know the young person best and can provide valuable information that does not breach the confidentiality of the relationship between the young person and the professional team. The Commission's carers, consent and confidentiality good practice guide² explains this in more detail but an inclusive approach to carers, relatives and people important to the young person cannot be understated.

What we heard:

Six parents/relatives of the young people in the unit chose to engage with us during our visit to Dudhope.

All parents or carers reported that the staff had discussed and agreed a care plan for their

child's care and treatment. Not all of the young people had agreed to their relatives' inclusion so this impacted on how involved they were. Those not given permission described most staff showing compassion for how difficult this was for them.

For those who had full permission to be involved, all felt able to ask questions about their young person's care and treatment with experiences of their involvement mixed with one describing their experience as "fantastic" and another caveating that "a lot of discussion happens behind closed doors". All, however, confirmed their trust and confidence in the staff providing the care and treatment.

"They're doing all that they can".

With reference to both nursing and medical staff we heard:

"As awful as this has been it could be much worse if it wasn't for the great staff"

Family therapy was highlighted as a positive intervention but that unfortunately it does not happen often enough.

Review of all case records suggested that the parents/carers of all the young people were involved in some form in their young person's care planning and given appropriate support.

One parent told us that they could not access the ward area and see where their child was sleeping. Staff confirmed that this should have happened during admission and it may be that something was happening on the ward at that time. Nursing staff agreed to rectify this immediately.

Half of relatives/carers said there were enough things for the young person to do in the ward/unit throughout the week and weekends/evenings. Some explained that their young person was still very unwell and not able to participate or did not like engaging in groups or preferred to keep their own company.

An adult carer support plan had not been discussed with the majority of relatives/carers. Only one carer had heard of this, and they spoke positively about involvement of a third sector provider organisation which supported them.

We heard that Dudhope compared favourably to experience of another national inpatient setting for children and young people.

There was a family flat on site where one family could stay at a time. However, we heard that due to demand, some families stayed in hotels that were funded by the Scottish Government Young Patients Family Fund. We heard suggestions that a "family suite" where multiple families could stay, with access to kitchen and laundry facilities would be ideal. We were told that there were no on-site facilities to purchase food or drink. For families visiting their young person in the unit, specifically when accessing the visiting rooms in the therapy corridor, staff support was required when hot drinks and toilet facilities were needed. This was due to the risk of ligatures in this area and requirement for doors to be locked.

On a sliding scale of five points from very satisfied to dissatisfied, one relative/parent took a neutral view whilst others described being satisfied or very satisfied with the care and treatment provided to their young person at Dudhope.

Staff working directly on the unit

What we expect:

The 2020 Child and Adolescent Mental Health Services (CAMHS): national service specification³ explains the Getting It Right for Every Child (GIRFEC) approach and confirms that CAMHS should work on a multiprofessional basis towards shared decision making and formulation. We therefore expected to find a multidisciplinary approach to the care and treatment of young people in Dudhope Unit underpinned by respect for individual roles and contributions and characterised by positive collaboration between professionals.

What we heard:

There is a wide variety of expertise and specialisms who contribute to the care and treatment provided at Dudhope Unit. From mental health nursing to medical, psychology, occupational therapy, family therapy, carer support, dietetics, physiotherapy (vacancy filled recently), pharmacy, speech and language therapy (on maternity leave currently, no cover) and a long-standing 18 month social work vacancy. We are grateful to the 15 staff who took time to speak with Commission visitors and/or completed the questionnaire provided.

All staff clearly expressed their job satisfaction with staff who have worked at Dudhope more than 20 years stating they “love it” “I feel that I was meant to be in this job” and others explaining why they enjoyed their roles.

“Being with the young people and seeing that spending time with them makes a difference to how they feel”

“Helping the young people to get them through to recovery and through to the finish of their care and treatment - it’s very rewarding”.

Staff consistently referenced the value of the multidisciplinary team (MDT) where there is mutual respect for different roles and responsibilities.

“There can be a lot of disagreement in the MDT meetings however no matter what your grade/band, you are encouraged to provide your view and this is respected. I have never worked in MDT that supports a non-hierarchical MDT approach to decision making”.

“...we do not always agree on care planning and treatments however there is healthy discussion, respectful and the issues can be resolved”.

“there’s a really good team here and we all get on with each other”.

There was a shared commitment to ensure that young people were fully aware of their rights, whether detained in hospital or receiving care and treatment on a voluntary basis with advocacy services and MHOs seen as key partners. Teaching staff also confirmed their commitment to ensure young people are aware of their right to education (Article 28) noting that the school is a Rights Respecting School and is heading towards a silver accreditation. We were told that local authorities are billed for this education accordingly with no issues.

Staff across disciplines reported that they understand the relevant consent and decision-making requirements of legislation.

Most staff confirmed that they had received child and adult protection training (primarily via

LearnPro, an online training/learning system) and most staff reported that they feel confident and competent in their reporting duties in relation to adult/child protection. (No firm assurance was given that there was understanding that young people aged 16-18 years may be subject to adult support and protection rather than child protection legislation however).

“The number to call is on our intranet. Charge nurses ensure the wider team are aware of this and when to use it. No social worker currently attached to the unit which is a loss as the previous one was a great help with these issues”.

All staff reported that they can speak up if they see practice which is not the best it could be. They felt “supported to do so” and were confident the matter would be acted on.

When we asked if staff felt supported to do their job to the best of their ability, all staff replied positively. This was explained in terms of having regular valued supervision, team support, scenario-based learning sessions and supportive line managers. The leadership of the service manager was singled out in particular.

We asked staff whether there were any challenges in relation to managing smoking/vaping as per legislative requirements. We were told that nicotine replacement therapy (NRT) is available and offered. A consistent approach was described with young people aware of the law and said to manage this okay.

When asked what gets in the way of giving the highest quality of care and treatment staff want to give to people, bureaucracy and inflexible approaches of some nursing staff were mentioned. There was also a view that having nursing staff located upstairs in the Dudhope building and other disciplines in the lower part could create a ‘divide’. We were told that a dedicated activities coordinator would be a useful addition to the team and universities’ support of students on placement could be improved with better preparation of students prior to practice. Social care provision was also said to cause discharge delays at times.

Where young people were admitted from out of the area, there were challenges regarding links with their local health teams and frustration about staff at Dudhope not being able to follow the young person’s care through or indeed receive feedback on how they are getting on.

Advocacy

What we expect:

The Mental Health (Care and Treatment) (Scotland) Act 2003 is clear about the vital importance of independent advocacy to ensure people’s own voices are heard. Young people and adults have a legal right to independent advocacy whether they are subject to compulsory measures under the act or not. This right applies to everyone with a mental illness, personality disorder, learning disability, dementia or related condition, and to all types of independent advocacy⁴ Section 259 of the Act enshrines this in law.

We therefore expect that all patients are offered independent advocacy support, and we would expect commissioned advocacy services to include specific advocacy expertise to enable young people to have as much control and influence on their care and treatment as possible given their current circumstances.

What we heard:

The advocacy service, Partners in Advocacy, is available to young people at Dudhope (excluding those young people from Aberdeen or Aberdeenshire who are supported by North East Advocacy instead; there were no patients from this geographical area when we visited). Partners in Advocacy are not a specialist child/young person advocacy service; however, two members of advocacy staff are dedicated to working with the young people at Dudhope Unit (they also work with adults elsewhere).

We met with the two staff who primarily provide advocacy support to young people in Dudhope. There were nine young people in Dudhope but Partners in Advocacy only had current contact with two of them. Four of the current inpatients had not been referred to advocacy services (including two detained according to the Mental Health (Care and Treatment) (Scotland) Act 2003) however, advocacy staff were confident that this was likely because it had been offered by staff in Dudhope but refused by the young person.

Advocacy staff believed that their service was promoted well within Dudhope and that all staff respect and value the role. We were told about some time being invested by advocacy services to engage in informal activities with young people to promote the role of advocacy but this did not increase uptake as had been hoped.

We heard that advocacy would support young people to raise concerns from 'time to time'. Examples given included bruising following restraint or the trauma associated with nasogastric tube (NGT) feeding. It was explained that, in these circumstances, Dudhope staff would investigate and meet with the young person to talk through the concerns. Advocacy would then check that the young person was satisfied and advocacy would support further if not. Dudhope staff were described as "responsive" when concerns were raised on behalf of an individual.

Mental Health Officers

What we expect:

Mental health officers (MHOs) have statutory powers under the Mental Health Act to support the care and treatment of people whose mental health condition may require the protection afforded by legislation.

As social workers, MHOs' responsibilities include care planning, assessing mental health need and whether compulsory intervention may be required as well as ensuring the rights and welfare of individuals is protected. It is a critically important role and we would expect active involvement by MHOs in the care of young people whose liberty has been impacted by detention in hospital against their wishes. We would also expect that each young person has a current and relevant social circumstances report (SCR) on file which has been sent to the key recipient, the responsible medical officer and copied to the Commission (section 231 Mental Health Act). The content of an SCR is clearly set out in the Mental Health (Social Circumstances Reports) (Scotland) Regulations 2005 and their purpose in the Code of Practice (Volume 1 Chapter 11). The Commission has published good practice guidance in relation to SCR provision⁵ and also monitors the provision of these statutory reports.

What we heard:

Three MHOs provided their views as part of this visit/inspection process. Despite repeated attempts to contact the other two MHOs, they did not respond. All were involved in working in partnership with the young people on the unit. MHO visits to the ward were not particularly consistent, for example, three visits in eight months compared to more regular contacts including multiple attempts to make regular contact but this not always being possible based on the individual needs of the young person.

“2 x weekly prior to the granting of the CTO with 1 x fortnightly contact since this time”.

The three MHOs said they were routinely invited to the multidisciplinary ward meetings and described the unit and staff as accommodating and inclusive.

The MHOs confirmed that they feel they are confident and competent in relation to their child protection/adult protection responsibilities and would have no hesitation in raising any concerns if there were any.

We were told that social circumstances reports (SCRs) were prepared or being prepared for three of the young people. We expected to see five reports completed or in progress. National standards for MHO services are clear that MHOs require to fulfil their statutory duties in accordance with the principles of the legislation, and the associated Codes of Practice, and managers require to enable this. Whilst an SCR may serve little or no practical purpose, this should be stated. Missing SCRs are not acceptable.

Whilst the general MHO experience of Dudhope was positive, some concerns were raised about communication with MHOs out with the fortnightly MDT meeting. We heard that key information was not always passed on timeously, for example if a young person had absconded or when passes home were organised.

What else did we hear and learn?

What we expect:

We expect a culture of openness and respect for the Commission’s duty in law to seek and receive a wide range of information including access to patient records. We also expect leaders to facilitate this process and to support their staff during the time the Commission and Healthcare Improvement Scotland are both on and off site.

What we found:

All operational staff we spoke with across the range of disciplines spoke openly about what works well at Dudhope and offered suggestions about how things could further improve.

Throughout our visit, we observed many members of nursing staff and some of the wider MDT on the unit; they were visible and available. We witnessed nurturing and caring interactions between the young people on the unit and staff.

We heard from young people that none of the staff were too busy to spend time with them.

The following are the key findings which emerged from what we heard, what we observed and what we read in case records, cross referencing with incident records.

Key findings

Multidisciplinary Team

We heard about a well-functioning team approach where there was mutual respect for roles and differences of view which were heard, considered and agreements reached. There was empathy, compassion and a strong focus on the experience of the young people.

Innovation

The unit has developed resources for children and their families on a range of topics including the use of technological advances to increase the accessibility of information. This has resulted in care being person-centred recognising young people as unique individuals. Padlets (which includes using QR codes to take you to relevant websites / information) are regularly used for this purpose. There has also been specific work on developing resources to support siblings, which we heard positive views about.

Family and carer support involvement

Families/relatives told us that they generally felt included and there was a range of supportive resources for them, including siblings.

They confirmed their trust and confidence in the staff providing care and treatment at Dudhope Unit.

The positive impact of the role of the carer support worker was clearly evidenced.

Where permission was not given by a young person to share information with family/relatives, staff were generally sensitive to this, supporting relatives whilst not breaching confidentiality.

Activity / Education

Activity programmes were varied, person-centred and focused on young people's interests within and out with the unit. Our observations and the feedback we received suggested evidence of an 'activity culture' supported by the occupational therapist.

We heard that this could be further enhanced with the addition of an activities coordinator.

We heard positive views about the school "the school is fantastic". It was clear that this is a well-resourced facility which is flexible, supportive and reactive in its approach to meeting the educational needs of the young people. This commitment to provision of education based on the individual needs of the young person was irrespective of which local authority they came from. It was good to hear that the school is a Rights Respecting School and is heading towards silver accreditation.

Staffing gaps

Psychology: there is a lack of psychology provision in the unit to undertake one to one interventions. Psychological formulations had been completed by the family therapist, with the contribution by the consultant clinical psychologist, to inform and support risk assessment and care planning, this gap was highlighted by young people, their families and staff on the unit. It was therefore good to hear that the psychology vacancy was to be filled soon after our

visit.

Social work: There was no social worker based in the unit and the post had been vacant for 18 months. However, we were told that the vacancy is currently undergoing recruitment and we look forward to seeing the post filled. In the meantime, we were told that if there was a requirement for a social worker, staff made a referral to the locality team and that they were usually responsive. We were concerned about a lack of direct social work input and understanding among some staff at Dudhope about their safeguarding duties in relation to adult support and protection legislation. Further awareness training is therefore required. Having a dedicated social worker would also enhance this knowledge and provide onsite advice and guidance. This is discussed later in this report.

Use of restraint

There is no specific piece of legislation or Scottish guidance dealing with restraint, setting out what is lawful in a hospital and what is not. The National Institute for Health and Care Excellence (NICE) provides guidance on the use of restraint for children and young people (NG10)⁶ and although it refers to English legislation, the principles can inform practice and local policies in Scotland. All practice however, should be informed by human rights law, specifically Article 3 (prohibition on torture, inhuman and degrading treatment), Article 8 (respect for autonomy, physical and psychological integrity) and Article 14 (non-discrimination).

Where restraint is considered necessary it should be the minimum required to deal with the agreed risk, applied for the minimum possible time⁷. The National Safety Council suggest ideally having up to five people present to safely control a patient⁸.

Four of the nine young people at Dudhope had experienced restraint during their admission according to staff and records (two of whom had experienced this on one occasion only). Where restraint was on more than one occasion this related to NGT feeds or keeping a young person safe. Where NGT feeds were required, staff described offering gentle reassurance and a low stimulus environment. They told us that a nurse would usually be on each arm providing light holds to guide the young person into the treatment room onto a beanbag, with support and reassurance given at all times.

However, we noted a lack of detailed recording around these significant events. In many cases, all that was recorded in the clinical record was very brief, for example, "four person restraint required to facilitate NG feed", but there were no details held in the clinical records such as events leading up to the decision to restrain, details of any de-escalation techniques tried, details around the restraint, whether medication was used to support the young person during the restraint, if body mapping was carried out post restraint and whether post restraint support was offered. We raised this and were told that this information is contained in the electronic incident record system (Datix). Datix data, however, does not form part of the young person's clinical records and it therefore meant that the clinical records were missing key clinical data that needs to be contained in them.

On review of the Datix data, it would appear that there was an appropriate response to reportable events. When restraint was used, there was detailed documentation regarding the antecedents to the restraint, the number of staff involved, the restraint position (i.e. prone, supine), the length of time the individual was restrained for, and whether post incident

support was offered and/or delivered to the individual. However, there was inconsistent recording around whether the physical health condition of the young person was monitored during and following each restraint. We found reference to daily vital signs being monitored, but this was not relevant to the event itself.

NHS Tayside's violence and aggression management policy states that: "to maintain skills and promote safe practice, staff should update themselves in theory via Staffnet, LearnPro modules, relevant leaflets, information packs, etc and attend refresher training in physical skills every 12 months". However, some staff involved in restraints recorded in Datix that their training was not up to date (this is discussed later in this report).

On many of the Datix reports, the senior member of staff who reviewed the report provided positive feedback on the incident report and frequently thanked staff for reporting the incident and offered support. It was positive to see the promotion of an open culture of reporting which is not a common feature of Datix reporting.

We asked if the management of aggression team were involved and gave advice about holds where staff felt there were difficulties doing this safely and were told they were. A recent example of this was the management of aggression team providing advice on safe seated restraint when administering nasogastric tube feeds.

Mealtimes and Naso-Gastric tube feed (NGT)

UK best practice guidelines⁹ for naso-gastric tube (NGT) feeding under restraint confirms that this practice should always be a measure of last resort when best efforts to support oral nutrition fail with subsequent deterioration in physical health. Whilst it is recognised that NGT feeding under restraint may be required in 'lifesaving circumstances', these circumstances are not clearly defined and require to be determined by the full multidisciplinary team.

Four young people were requiring NGT feeds during the time we visited or had received them previously.

The British Dietetics Association's best practice guidance (page 1) states "At the point of passing NGT the patient should be offered another opportunity to take nutritional supplements / water orally in order to ensure that least restrictive practice is being carried out and that every opportunity to take oral food and fluid has been offered".

One young person told us that:

"Staff did make lots of efforts to support me but did not work as I had strong anorexic thoughts at the time and no matter what anyone said to me, I would not have found this supportive".

Records confirmed bespoke arrangements in place to support young people, avoiding 'fear food', having overnight feeds, one to one discussions, dietetic input and regular monitoring and risk assessment.

NGT feeds were mainly done in the treatment room at Dudhope but where a young person struggled, and staff had difficulty moving them safely to the room, they might be fed in a communal area. When this was required, staff moved the other young people to other areas of the ward and would screen the young person to ensure their privacy and dignity.

Care planning

Electronic care records were stored on a system called MORSE, which was easy to navigate. There were also some key pieces of information stored in paper format.

We found that nursing care plans demonstrated a holistic, strengths-based approach to care and treatment. They were practical, clear and involved the young people and their families. Care plans were regularly reviewed, and whilst some reviews were detailed, others were brief and simply noted 'no change, continue with interventions'.

As noted above, we had concerns that not all restrictive practices and interventions were being care planned for. While we saw separate care plans for continuous interventions and seclusion, none detailed how restraint practices should be carried out. When such interventions are being used or anticipated we would expect to see a detailed care plan with de-escalation plan, steps to be taken and ways to reduce distress. The absence of this was a concern.

We saw detailed nursing risk assessments, but some of the risk management plans we viewed were not as comprehensive as we would have expected and did not fully correlate with the assessed risks. This was particularly apparent in some cases when perhaps five or six areas of risk were identified, but only two or three of these featured in the risk management plan. We were unable to view multidisciplinary risk assessments during our visit and from our inquiries, it is not clear that these exist.

On request, we were sent copies of formulations for some young people which also included a section for 'risk of suicide', but for no other identified or assessed risks. Some areas that may have benefitted from a formulation approach to risk included, risk of self-neglect, risk of social isolation, risk of lack of education, risk around family contact/no family contact, etc.

On review, while the formulation of risk was detailed and clinically valuable in outlining the background, contributing factors and presenting difficulties, it was not accompanied by a clear risk management plan, so lacked the practical guidance needed for staff to understand how identified risks should be managed. We have noted this as an area for improvement.

Discharge care planning was under consideration for all young people apart from the most recent admission where the timing was not yet appropriate.

Mental Health Act legislation/authority to treat

The Mental Health Act provides the authority for compulsory treatment of individuals under strict circumstances and describes important safeguards for individuals as to how medical treatment, such as medication, NGT feeding and electroconvulsive treatment (ECT) may be lawfully authorised. Part 16 of the 2003 Mental Health Act¹⁰ describes these requirements which seek to ensure that the rights of patients are sufficiently upheld and protected at a time when they are unwell and may be unwilling to receive treatment or be admitted to hospital on a voluntary basis.

Following scrutiny of all records it was good to find that all mental health legislative requirements were in place including authority to treat certificates which corresponded to the prescribed psychotropic medication. Where Adults with Incapacity (Scotland) Act 2000

legislation was relevant, we found copies of the necessary paperwork and associated powers. We noted that audits are regularly carried out to ensure that the information is current and accurate.

A folder is held at Dudhope Unit containing copies of all detention paperwork and treatment certificates for ease of checking when dispensing medication. It is important that nursing staff are aware of their legal responsibilities when dispensing medication and this folder ensures that information is readily accessible to do so.

Rights and restrictions

The Commission's good practice guidance on Specified Persons¹¹ is clear that people who are in hospital should be able to keep contact with friends and family throughout their stay, and should, if appropriate, be able to carry on with their lives in as usual a manner as possible. However, it is possible to use section 284 of the mental health act and associated regulations to intervene where restrictions are assessed and deemed as necessary by the responsible medical officer. There was nobody subject to specified person legislation at the time of our visit to Dudhope.

A locked door policy was, however, in operation when we visited Dudhope. This was implemented as needed and reviewed daily. We were satisfied that this was proportionate to the needs of the young people being cared for. Where young people were subject to continuous observation we found the appropriate guidance in place, in addition to detailed person-centred continuous observation care plans.

There was clearly a focus on rights based care both within the unit and the school. The unit did not promote the take up of advance statements, however. Anyone has a right to make an advance statement, and we recommend that Dudhope build the offer of an advance statement into practice when the person is well, as part of discharge planning rather than expect that this is the responsibility of community based services.

We were able to view the Tayside mental health and learning disabilities seclusion protocol but feel there is a need for an underpinning seclusion policy to guide this care and provide effective governance. A recommendation for improvement has therefore been made. We will follow up with NHS Tayside to receive a copy of the Tayside Health Board wide seclusion policy to which this protocol should relate to ensure consistency of practice across the Board area.

Systems, Leadership and Governance

What Healthcare Improvement Scotland did

During our safe delivery of care inspection, we:

- inspected the unit environment
- observed staff practice and interactions with patients, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we asked NHS Tayside to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and inform any virtual discussion sessions.

Clear vision and purpose

As previously stated, Dudhope Young People's Inpatient Unit is the Tier 4 specialist Child and Adolescent Mental Health Inpatient Unit (CAMHS) for the North of Scotland.

The Dudhope Unit is a purpose built 12 bedded unit which consists of a kitchen, large communal area, two small lounges, treatment room, sensory room and dining area. The residential unit is on the upper floor with a school, gymnasium and conference room on the ground floor. The upper floor has several consultation and meeting rooms and a wellbeing room. The ground floor has a large bright reception area which has available seating. We observed there were a number of posters in this area with information relating to the unit including the Dudhope monthly update newsletter. Evidence provided included the newsletter for December 2025 which included school updates, information on decider skills sessions and music and art groups. Decider skills will be discussed later in this report.

The unit had one available bedroom on day one of our visit/inspection, three on day two and five on day four. There were also a number of young people on pass leave. A pass is when a young person has planned leave from the unit such as during weekend home leave.

A delayed discharge refers to situations where a patient, who is clinically ready to leave hospital, cannot do so because the necessary care, support, or accommodation is not available. We can see in evidence provided that there is an entry on the NHS Tayside clinical risk register relating to delayed discharges of a significant length of time. We were provided with the August minutes from the Dudhope young person's unit management team meeting which includes the risk register as part of the standing agenda items. This documented that there were no new updates relating to the risk register entries including delayed discharges. We asked senior managers for an update who advised that as of January 2026 there were no young people with a delayed discharge on the unit and the risk had therefore been removed from the register.

From March 2023 to March 2024, 34.2% of young people under the age of 18 were admitted out with NHS specialist child and adolescent mental health services across Scotland (Public Health Scotland Quality Indicator profile for Mental Health, November 2024). There were no young people awaiting admission to the unit during the week of our onsite visit/inspection. However, there were three out of area young people in the unit awaiting available beds in their regional Child and Adolescent Mental Health Service (CAMHS) inpatient units.

Evidence provided included the parents and carers and young persons 'out of area' advice letter. These explain that the young person has been admitted to Dudhope Unit due to lack of available bed at their regional CAMHS inpatient unit. It includes answers to frequently asked questions, including advising that the young person's local CAMHS team will be involved throughout their admission, including clinical meetings and decision making. It also documents that the young person will be transferred to their regional unit as soon as able. The letter recognises that young people and their families may have built therapeutic relationships with staff and that transferring them may be unsettling. It is highlighted that in exceptional circumstances, if a young person is detained under a Compulsory Treatment Order as part of the Mental Health (Care and Treatment) (Scotland) Act 2003 that they may have the option to appeal the transfer.

Senior managers advised that if there was no available bed for young people from the North of Scotland at the Dudhope Unit that they would be admitted to another regional CAMHS unit. However, if there's no available beds within the CAMHS units across NHS Scotland they would be admitted to a bed within their local NHS board such as adult mental health unit or paediatric ward with oversight by CAMHS services.

Evidence provided includes the North of Scotland CAMHS intensive home treatment service programme. This describes that the North of Scotland CAMHS Network is developing an intensive home treatment service. This will include short term multidisciplinary interventions as an alternative to inpatient care including digital care delivery. Integrated care pathways will be developed with each NHS board and will include frameworks, standards of care and clinical pathways including for eating disorders, personality disorders and psychosis. The intensive home treatment service will be delivered by the local CAMHS multidisciplinary team. We asked senior managers for an update on this who advised that the implementation of the service is currently in its second phase with plans for further development throughout 2026. We were also advised that a suite of key performance indicators and outcome measures are being developed to monitor the impact of the service.

It is highlighted within the clinical governance meeting report for the Dudhope Unit for August and October 2025 executive summary that there has been a notable rise in out of area admissions to the unit from the other regional CAMHS Units. It is also documented that there will be ongoing monitoring to assess any impact on service provision.

We observed a poster in the main corridor leading to the residential unit which included several QR codes. When scanned these open links to online information resources. These include, carers welcome pack, young people's admission pack, support for young people family and carers, and decider skills. The welcome to the Dudhope Young Peoples Unit electronic resource (for young people), includes a number of links to other information including support time resources. These include distraction and self-care ideas, word searches, quizzes, mindfulness videos and self-care activities. The information describes that the support time resource was developed to enable staff and young people to share and engage in meaningful activities. It is documented in evidence provided that the electronic resources have been presented and shared with a number of external teams, including other regional CAMHS units and adult mental health units. In addition to the online resources there are paper welcome packs for both carers and young people of which both include the QR codes to the available electronic resources.

During our onsite visit/inspection we observed posters in the unit for the carer coffee mornings which are held on the first Sunday of the month. We can see that details of the meetings are included in the carers welcome pack and explain that they are facilitated by unit staff and enable carers to ask any questions and gain support. The online resource for carers and families has a variety of links of available support for carers and families including financial advice, and support and links to local carer support centres throughout Scotland.

The welcome pack highlights that the Dudhope Unit has flexible visiting. However, it is recommended that visiting is avoided during mealtimes, school hours and group activities where possible.

The unit has a family flat which families can book. The flat is next to the unit and has a living room, kitchenette, bathroom and bedrooms. Senior managers advised that if the flat is already in use, reception staff will support families to book alternative accommodation in the area. It is highlighted in the families welcome pack that the Young Patients Family Fund can cover the cost of visiting including travel, meals and accommodation and advises to contact reception for any further advice. The Young Patients Family Fund is a Scottish Government fund and is available for parents, primary carers or sibling (aged under 18) of a young person who is receiving inpatient hospital care. However, it is noted earlier in this report that families and staff would prefer a dedicated resource which has space for more than one family.

Dudhope Unit has a link charge nurse who is a consistent point of contact for staff and families/carers. Senior managers advised that the role includes being the link between the nursing team, wider multidisciplinary team and young people and families/carers. The role also includes case management by overseeing young people's care including ensuring families are involved in key processes such as pass management. The link charge nurse contacts families/carers within the first week of the young person's admission to arrange a welcome meeting or telephone call. This is to provide families/carers with information about the unit and allow them to ask questions and share any information. An early care planning meeting will also be arranged within the first week of the young person's admission. This is with the multidisciplinary team, young person and families/carers and is either in person or via online call. The aim of the meeting is the sharing of information, agreeing the aims of admission and planning next steps.

Staff described the role of the unit carer support worker which includes providing emotional and practical support for families and carers, including providing guidance on accommodation and travel arrangements when visiting. The carer support worker also liaises with CAMHS community teams and network nurses to ensure families/carers have access to appropriate support.

Senior managers described that part of the carer support worker role is to meet with carers/families regularly to enable feedback. Young people and carers/families can also provide feedback at team meetings and young people can provide feedback to nursing staff during their 1:1 meetings and at the unit community meetings. The community meetings take place twice a week and all young people are invited to attend alongside a small group of staff. Young people can raise concerns and ask questions and there is a suggestion box which is checked during each meeting. Recent requests in the suggestion box have included access to online streaming platforms for music and films/TV shows which have since been implemented. There is also a "what matters to you" box in the reception area which can be completed

anonymously.

Senior managers advised of the “what matters to you day” which takes place during the first week of June. This takes place in the gymnasium in the unit and includes staff, young people and families. Actions from the day will be added to the “you said we did” board which is displayed at the top of the stairs leading into the residential unit. The “you said we did” board anonymously displays what feedback young people or families/carers had given and the action taken by the Dudhope staff team in response. These included the organisation of two “PATNICS” which are described as picnics with dogs in response to the request to have more time with therapy dogs. Further feedback includes that there were not enough activities for young people to do in support time (post meals). Response to this includes the creation of a support time box which has games and craft ideas, the development of the online support time resource and a reminder that the sensory room and art room can also be used during support time.

Senior managers also advised of the unit’s feedback committee, this meets quarterly to maintain oversight of all forms of feedback including reviewing themes and trends. We were provided with the action log from these meetings which includes description of feedback, action to be taken, person responsible, date completed and any comments. The feedback is colour coded for “celebration” and “area for improvement” and documents feedback from sources such as parents/carers, young person, community meetings, you said we did board, carers coffee mornings, multidisciplinary team, discharge core group and the care opinion. The care opinion is an independent online platform which enables people to provide feedback to NHS boards in relation to experience of care.

The action log has been completed since 2023 for each quarterly meeting. Feedback in relation to areas of improvement for 2025 include inconsistency in mealtime portion size. Actions for this include forwarding to the mealtime management group and consideration of further training for nursing staff. We can see that it is documented in the action log that this has been completed. Celebration feedback includes positive feedback from young people regarding the community meetings and also positive feedback from student nurses in relation to their induction onto the unit. Senior managers explained feedback from the meeting is shared with staff through an electronic platform that all staff can access. Information can also be cascaded via the daily safety brief document which is read through at each shift handover and daily rapid rundown.

The unit holds a post discharge core group meeting for all young people approximately six weeks after discharge. This is a 30 minute meeting which is attended by the young person’s clinical team and their home community CAMHS team. During the meeting the team identify any areas of good practice and any identified areas for improvement. Feedback from carers/families and young people is also provided where able. The Dudhope Unit feedback committee collects themes from the meetings to enable any quality improvement projects or training. These have included further training for nursing staff in the alcohol withdrawal policy and the provision of a wider range of books in the unit library.

In the six month period prior to our onsite visit/inspection there was one formal complaint received relating to services delivered in the Dudhope Unit. Senior managers described the response to the complaint including provision of additional support, implementation of duty of candour and provision of an apology to the young person involved. Duty of candour is a legal

requirement that involves NHS organisations being open, honest and supportive of individuals affected by unexpected or unintended incidents that have or could have resulted in harm. See [here](#) for further information.

During our onsite visit/inspection staff told us of a number of quality improvement initiatives. These include, but are not exhaustive of, a review of the team meeting process, the letters for out of area young people and their carers/families, development of a full day induction for student nurses, implementation of Safewards and development of information booklets for siblings of young people who are admitted to the unit. These will be discussed later in this report.

Each young person has a 30 minute fortnightly multidisciplinary team meeting which can be attended by their families and carers if the young person gives consent. This meeting provides an update on all aspects of the young person's care and treatment. The young person receives a team meeting report the day before the meeting and can add any comments or questions to this. Families/carers can also receive a copy of this report if the young person consents. Members of the multidisciplinary team who attend the meeting include, medical staff, psychology staff, nursing staff, allied health professionals and teachers from the Dudhope school. Young people and their carers/families can join the team meeting either in person or online.

Senior managers advised that a review project of the format and function of the meeting had been undertaken by two staff members in response to feedback from young people, families and staff. A questionnaire was developed for relevant stakeholders including staff, patients and family/carers. We were provided with the summary of the review including questionnaire. This documents that of the 20 responses received 95% found the meetings helpful, 85% felt they were the right length and 80% were happy with the meetings being fortnightly. Recommendations from the feedback include, maintaining frequency and duration of team meetings, asking that all but essential people join the meetings virtually and team meeting outcomes to be directed toward the young person, rather than staff. Senior managers advised that all recommendations and actions have now been implemented.

Senior managers and nursing staff told us of the development of age specific information leaflets for siblings visiting young people in the unit. We can see in evidence provided that there is one leaflet for primary aged children and another for secondary school. The Primary aged leaflet is in an accessible easy read format including pictures and symbols. The leaflet explains how their sibling may be feeling, pictures of the unit and answers to questions such as what they can do to help, for example drawing them a picture. There is also a section describing how the young person visiting may feel and activities to do including colouring, simple word searches and advice on who to talk to if they need support.

The sibling booklet for those of secondary age includes sections on how to keep in touch such as visiting, text or voice note. There is also advice on who to talk to including a QR code which links to the Dudhope Young Persons Unit: support for young people, family and carers resource. This includes links to a number of available support resources including Young Minds. Young Minds is a UK based charity offering support and advice to young people with mental health difficulties and their families/carers.

Dudhope school is based on the ground floor of the building and is staffed by a principal teacher and two teachers. The school also has a classroom therapy dog. Senior managers

advised that if young people are unable to attend the school that education can be provided on the residential unit. During our onsite inspection/visit a number of young people were attending school and teaching staff were also supporting a young person in their room. Senior managers advised that teaching staff attend the morning safety huddle and can support young people to access lessons from their own mainstream school.

The young person's online welcome pack includes information about the Dudhope School. This advises of school opening times and that the curriculum will follow the subjects and courses set by the young person's mainstream school where able. It also discusses that young people can sit national examinations whilst at the school and careers advice can be provided. The welcome pack describes that the school has "fun Friday"; this is the last period of the day and includes activities such as games and music therapy.

Dudhope Unit has a poster in the shape of Scotland in the corridor leading to the residential unit which has information about the available advocacy services throughout the country. The young persons and family and carers welcome pack also includes information advising of the right to advocacy, how to contact services and advises that an independent advocacy worker visits the unit regularly. As part of our joint visit/inspection the Commission were able to speak with advocacy staff as noted earlier in this report.

NHS boards play a crucial role in child and adult support and protection. Adult and child protection training provides staff with the information required to promote the protection and wellbeing of adults and children. It also highlights the process to follow if staff are concerned that a person has been or is at risk of being harmed. We can see in evidence provided that 80% of Dudhope unit staff have completed adult support and protection training. We were also provided with training compliance for child support and protection training. This shows that 83% of staff have completed level one training, 67% level two training and 40% level three training.

Level one child protection training is aimed at all members of the health care workforce and provides information on what to do if they think a child is being harmed. Level two training is for staff who have direct and/or substantial contact with children and young people and families and carers. Level three training focuses on advanced safeguarding and covers more complex issues. We can see it is documented in evidence provided that there is a current focus on improving child protection training compliance within the next three months. A requirement has been given to support improvement in this area.

We asked senior managers what processes are in place for the review and oversight of any public protection concerns who advised concerns are escalated to the NHS Tayside public protection department advice line. We were also advised that as the unit is a regional unit that concerns may also be raised with the young person's local public protection teams and staff will also raise any concerns to the unit's senior managers. Details are recorded on the young person's electronic care records and are handed over at the daily rapid rundown to ensure awareness including any outstanding actions. The clinical team meet quarterly for clinical supervision with the NHS Tayside public protection team. This provides an opportunity to discuss or reflect on any public protection concerns enabling learning and increased awareness. We were provided with a number of NHS Tayside policies and pathways relating to child and adult protection as evidence. These include, how to make an adult protection referral seven minute briefing, public protection learning and development framework and NHS

Tayside clinical child protection policy.

NHS boards have a responsibility to comply with fire safety standards in accordance with NHS Scotland Firecode (2007). We did not observe any obstructions to fire exits during our onsite visit/inspection. However, we observed a “broken” sign on a fire door which had been reported the week prior to our visit. We discussed this with staff who advised that a number of fire doors had faulty hold open devices. We were also told that this was a long standing problem despite being reported several times to the estates department. We were also advised that in some instances doors were held open with door wedges as it can be difficult to hear staff and young people in other parts of the unit if the doors are shut. We raised this with senior managers during our onsite visit/inspection who advised that a walk round would be conducted with the senior management team the next day. Fire door hold open devices hold fire protection doors open but automatically release the door to close them in the event of a fire or power cut.

As part of this visit/inspection we asked for the fire evacuation plan, fire risk assessment and fire safety training compliance for staff in the unit. We can see from this that 84% of all staff have completed fire safety training and an annual refresher and tabletop exercise will be completed at the unit development day in November. A tabletop exercise is a discussion based training session where a facilitator presents a fire scenario. The Dudhope Unit fire evacuation plan was updated in May 2025 and not due for review until May 2026. It includes an evacuation flow chart and incident response team action cards and fire zone map of the unit.

The Dudhope Unit annual NHS Scotland firecode fire risk assessment and associated action plan (February 2025) highlights required areas of improvement throughout the unit. Of these, nine have been rated as medium risk including a number of fire door deficiencies such as excessive gaps, seals needing replacement and four doors having faulty hold open devices. We can also see that it is documented in the fire risk assessment that the hold open door mechanisms have not been working for approximately two years despite attempts by the estates department to repair them.

A moderate risk rating has also been given in relation to lack of full access to maintenance and test records to ensure a schedule of planned preventative maintenance is being carried out and any potential fire risks from lack of maintenance have been mitigated. Both of these risks have a “fix by date” of 31 March 2025 in the fire safety risk assessment action plan with the fire door maintenance being rated as high priority. The fire safety action plan also recommends that the estates department conduct six monthly fire door surveys.

We asked senior managers for an update on the fire doors and if they had been maintained since our onsite visit. We were provided with an updated fire safety action plan from December 2025 which shows that of 12 improvement actions, seven are awaiting an update from the property department. It is documented that the hold open devices have been escalated to NHS Tayside property department who have visited the site in November with contractors. We asked NHS Tayside senior managers for an update on this who advised that they are awaiting confirmation regarding timelines for the completion of the repairs to the fire doors. We were also advised that due to the clinical requirement for ongoing visual observation of young people in the unit an interim mitigation had been agreed to use door stops to hold open the doors which have faulty hold open mechanisms.

We asked NHS Tayside for assurance that the use of fire doorstops had been discussed with

NHS Tayside fire safety team and Scottish Fire Service. We were advised that both the Scottish Fire Service and NHS Tayside fire safety team are aware of the mitigations in place to use door stops to balance clinical and fire risk. We can also see in evidence provided that a risk relating to the fire doors has been added to NHS Tayside clinical risk register. Mitigation in relation to the use of the fire stops include, ensuring all staff are fully briefed on the risk and control measures including the requirement to ensure all fire doors are closed in the event of a fire alarm activation. We asked senior managers for a predicted timeline for repairs of the faulty hold open mechanisms of the doors and also other required maintenance to the doors as highlighted in the fire risk assessment action plan. We were provided with evidence that shows that a survey of the doors has now been completed. Senior managers advised that maintenance of the fire doors is scheduled for first week of February 2026 with an anticipated completion date of the end of March 2026.

It is also documented in the fire risk assessment that a number of portable firefighting equipment was due annual testing in July 2025. We asked senior managers for an update on this who advised this has been reported to NHS Tayside estates department for completion of testing.

It is documented in the updated fire risk assessment action plan from January 2026 that all of the outstanding actions from the fire risk assessment have a planned completion date of January or February 2026 or have had work actioned and are awaiting commencement. This includes the implementation of an NHS Tayside fire door procedure in relation to the action of conducting six monthly fire door surveys. Whilst we recognise improvements have been made to meet the recommendations of the fire risk assessment and Scottish Fire and Rescue Service survey a requirement has been given to ensure ongoing compliance with NHS Scotland "Firecode" guidance.

During our onsite visit/inspection staff told us that the Dudhope Unit heating system does not always work effectively which is mitigated by the use of portable oil and electric heaters. We can see that it is documented in NHS Tayside's clinical risk register that a fault was identified with the heating in November 2023 which affects multiple parts of the building such as the therapy corridor rooms and school. It is also documented in the risk register that contractors assessed the system in January 2024 but despite escalation via the health and safety committee and clinical governance committee the required work has not yet been completed. The risk register entry cites the use of electric and oil heaters as mitigation for the faulty heating. We asked senior managers for an update on this including if the heating was also faulty within the young people's bedrooms. We were advised that a specialist contractor has been appointed to undertake a review of the heating. Portable heaters are not used in the bedrooms due to potential risk such as ligature risk. Mitigations for the bedrooms include additional bedding and if able moving to a different room if a young person raises that they feel cold. We were also advised that one bedroom is currently closed due to ongoing low temperatures.

Portable Appliance Testing (PAT) is the process of checking electrical appliances to ensure they are safe to use and mitigate the risk of electrical shock or fire. It is documented in the fire risk assessment that not all portable electrical appliances within the unit had PAT testing labels on them and some that did were out of date. The fire risk assessment action plan gives the recommendation that a list should be compiled of all appliances that require testing. We can

see in the updated fire safety action plan that whilst the list has been completed there are ongoing discussions with the NHS Tayside property team as to who will be responsible for completing testing. We asked senior managers for an update on this who advised that it is aimed to complete PAT testing by the end of January 2026. It is also documented in the fire safety risk assessment updated action plan that the electrical installation condition report is out of date for the unit. We can see in evidence provided that NHS Tayside are awaiting a contract to complete these throughout the estate. However, we were not provided with a timeline for completion of this.

During our onsite visit/inspection staff told us that the lift to the residential unit had recently been fixed but prior to this had been broken for approximately one year. We asked senior managers for an update on this who advised the delays to the repairs were multifactorial including waiting for parts and change in maintenance contracts and specialist personnel. Mitigations included arranging visits on the ground floor of the building if required and use of an alternative route to access the residential unit, via a pathway at the side of the building. A requirement has been given to support improvement in this area.

Leadership and culture

Nursing staff we spoke with feel able to raise concerns and described visible and supportive senior managers and also a supportive clinical team. Staff told us they are able to access training and clinical supervision timeously and wellbeing support if required. We were also able to speak with a student nurse who advised they felt supported and that the unit was an excellent placement. We were told of staff development opportunities including working on quality improvement projects and being trained to deliver in house training such as basic life support.

Nursing staff we spoke with did not raise any concerns relating to staffing and advised that if they do have concerns, they feel comfortable to raise them. As part of our joint visit, the Mental Welfare Commission spoke with members of the wider multidisciplinary team including medical staff as noted earlier in this report.

The NHS iMatter survey is a staff experience tool which is completed yearly to enable staff, teams and health boards to understand and improve staff experience. The survey asks staff to think of their experience in relation to a number of questions. These include but are not exhaustive of questions relating to the team the staff member works in, their direct line manager and organisation. There are three separate iMatter surveys completed by the Dudhope team. These include the nursing team, administration and multidisciplinary team (non-nursing) and North of Scotland Tier 4 Regional Network Team. We asked senior managers to provide us with any themes and actions from these. We were advised that themes noted include, provision of feedback, staff to feel supported, recognised and acknowledged and recognise and promote positivity. The iMatter action plan includes actions specific to each survey. These include but are not exhaustive of promoting the use of positive feedback such as learning from excellence and enabling increased attendance at staff development days.

The multidisciplinary team for the Dudhope Unit includes but is not exhaustive of nursing staff, psychiatric medical staff and psychology and therapy staff. The Allied Health Professional (AHP) team includes occupational therapy, physiotherapy, speech and language therapy, dietetics and AHP assistant practitioners. Staff advised that the assistant practitioner role includes

working with speech and language and occupational therapy staff as well as physiotherapy and dietetics.

NHS Tayside utilise an electronic staffing system which reports real time staffing requirements based on roster demand and patient care needs. This system takes into account the acuity and dependency of young people versus available staffing numbers. Senior managers advised that professional judgment is used to update this twice daily to monitor staffing levels against acuity and dependency. Staffing levels are reviewed at the Dudhope Unit morning rapid rundown alongside any action to mitigate any identified staffing concerns. Any additional concerns will be escalated to senior managers throughout the day. At weekends and out of hours escalation of concerns is through the on call manager and via the wider mental health and learning disabilities morning huddle. We were also advised that there is a weekly NHS Tayside mental health and learning disability huddle which includes a review of staffing.

Mitigation of staffing concerns include realignment of the rota, support from the multidisciplinary team, regular staff working additional hours, including CAMHS staff from across NHS Tayside, and escalation of shifts for supplementary staff. Supplementary staffing includes substantive staff working additional hours, staff from the NHS board's staff bank or staff from an external agency. If risk is unable to be mitigated an incident report will be raised and business continuity plan implemented. We were provided with a copy of the NHS Tayside business continuity plan, CAMHS, YPU (Young Persons Unit) and Dundee adult psychological therapies services as evidence. This includes minimum staffing levels required for the unit and actions to be taken if these are reached and the business continuity plan implemented. This includes the use of supplementary staff including medical locums and support from further NHS Tayside CAMHS teams.

Evidence provided includes the Dudhope nursing dependency rating tool. This is a traffic light system which provides a numbered and colour rated dependency score. A green (acceptable) rating requires no further action, yellow (adequate), look to improve at next clinical review, amber (tolerable), look to improve in 72 hours and red (unacceptable), make immediate improvements as per business continuity plan. The tool includes a number of dependency indicators which are scored from one to five. These include number of episodes of self-harm, absconding, nutrition via nasogastric tube and number of additional staff hours. We were able to attend the morning rapid rundowns of the unit on the first and second day of our inspections and observed that the dependency score was discussed.

The Dudhope Unit holds a rapid rundown at 09:00 in the morning. We observed that these were concise, person centred, structured, inclusive and included members of the multidisciplinary team. This included allied health professionals, nursing staff, medical staff and senior managers. The meeting included a brief hand over and update of each young person's care. Safety information was also discussed such as young people who are on continuous interventions, young people should not use the kitchen and that the locked door policy is in place. Staffing, including which nursing staff are coordinating, and vacancy rates were also discussed. We did not observe any staffing concerns raised during the rapid rundowns.

We were provided with the rapid rundown safety brief documents for both days we were onsite. These include each young person's risks and any critical incidents in the previous seven days such as self-harm and ligatures. Relevant information is also documented including specific diets and if unable to attend school. There is also a section to document staffing

concerns including mitigations. We can see from the safety brief document that there was a yellow dependency score for both days.

During our onsite visit/inspection staff told us they feel comfortable to raise concerns relating to staffing and that staffing shortfalls are covered by a mix of substantive staff working additional hours or supplementary staff who are familiar with the ward from NHS Tayside nursing staff bank. Evidence provided by senior managers highlights that bank staff are required to have the required skills before booking shifts including prevention and management of violence and aggression training. Bank staff without these skills will only be considered if other mitigations have been unsuccessful and after further risk assessment and approval by senior managers.

We were provided with supplementary staff use for the six months prior to our onsite visit/inspection. We can see from this that the total registered nurse supplementary staff hours were 578.5. The majority of which (510.75) were covered by substantive staff working additional hours. Of the 1785.2 hours of health care support worker supplementary shifts in this time period, 1717 were covered by supplementary staff from NHS Tayside staff bank. We discussed this with senior managers who advised this was due to increased acuity and dependency including the number of young people requiring continuous interventions. There were no agency staff utilised during the six months and no use of supplementary staff for non-nursing roles. We did not see any supplementary staff on duty during the first two days of our joint visit/inspection. However, we can see in evidence provided that there was one supplementary staff member on the late shift on both the 23 and 26 of October.

The Health and Care (Staffing) (Scotland) Act 2019 stipulates that health boards have a duty to follow the Common Staffing Method (CSM). This is a multifaceted triangulated approach which includes the completion of a speciality staffing level tool and a professional judgement tool concurrently run to support NHS boards to ensure appropriate staffing and the provision of safe and high quality care. We can see in evidence provided that these have been completed by the unit in November 2025. Senior managers advised that a CSM report will be produced from the output of the tools. Following triangulation of the tool metrics and local content any suggested changes to the staffing compliment or risk escalation will be shared with the senior management team as part of the workforce planning for the NHS Tayside children's division.

As part of this inspection/visit we asked NHS Tayside to provide evidence of any incidents or adverse events reported by staff through the electronic incident reporting system for the six months prior to our inspection. Of these we could only see one incident report submitted in relation to inadequate staffing numbers. This related to a young person not receiving nutrition via nasogastric tube due to increased acuity and dependency on the unit and inadequate staffing numbers to safely administer the nutrition. It is documented that staff spoke with the young person and provided an apology and explanation as to why the nutrition was omitted and this was noted in the young person's care records and handed over to the next shift. Adverse events and incidents will be discussed further later in this report.

Workforce pressures including recruitment and retention of staff continue to be experienced throughout NHS Scotland. Senior managers provided us with sickness absence and vacancy rates for the unit. We can see from these that as of January 2026 there is one healthcare support worker vacancy, and the social worker post is also vacant. Senior managers advised that the vacant social work post is currently covered by the young person's respective locality

social work department and local health board public protection teams. Both posts are currently undergoing recruitment. We consider a high vacancy rate to be greater than 10% with the aim to achieve a sickness absence rate of 4% or less. However, we appreciate percentage rates may be high if base numbers are low as this represents a proportion. We can see in evidence provided that the combined sickness rate for the multidisciplinary team was 7.65% in November which is a reduction from September and October. We asked senior managers how staff are supported during sickness absence. NHS Tayside utilises the NHS Scotland workforce attendance policy. This policy provides a structure for managers to support staff during sickness absence and on their return to work such as a phased return and occupational health support.

Approximately one percent of incident reports submitted in the six months prior to our onsite visit/inspection were due to violence and aggression from young people towards staff. We asked senior managers what health and wellbeing support is available for staff. We were advised that all staff can access NHS Tayside wellbeing intranet page. This includes the contact number and email address for the staff wellbeing centre. It also documents that there is a member of the team available by phone 24 hours a day. We also observed during our onsite visit/inspection that there were pens available for staff with the staff wellbeing service number on them. Staff told us there is a weekly value based reflective practice group for all staff and monthly clinical supervision.

Clinical supervision is a proactive process to support development and professional growth by offering dedicated time, feedback, and guidance in a psychologically safe space to critically reflect on practice. Values based reflective practice can be used by anyone working in health and social care and uses the principles of reflective practice with the aim to improve staff and patient experience. NHS Tayside's spiritual care chaplain attends the unit weekly and provides ad hoc or planned group or individual staff sessions. The Dudhope unit also has a staff wellbeing champion and available QR code which provides information on available wellbeing resources. We also observed the staff "shoutout board" where staff can give positive recognition to other staff for something they did well.

Personal alarms are available for staff who work on the unit to summon help quickly in an emergency. We observed a small number of incidents where staff had reported that their personal alarms had been pressed but had not worked. We asked senior managers for an update on this who advised that staff are now instructed to test their personal alarms at the commencement of each shift to ensure they are fully charged. Alarms are also tested if they have been used. If an alarm is found to be faulty a replacement is issued and the faulty one returned to the manufacturer. We were also advised that weekly testing and recording of the alarm sensors has also recently been implemented.

Staff and senior managers described debrief sessions for staff after incidents including episodes of violence and aggression. These can be requested by staff and can be either immediately after the incident or at a later date. We were also told of the development of a weekly "Pot Luck Pass Times" support group for staff. We asked senior managers for further information on this who advised that three members of the Dudhope team had attended a six day transformational practice course. The programme enables participants to become an effective facilitator of transformational practice development including how to influence and change culture and practice. The "Pot Luck Pass Times" group was developed in response to a culture

survey undertaken by the staff who had attended the transformational practice development course. The group was developed to maintain/improve working relationships. The group is designed as a drop in group where staff can get to know each other better; this includes staff bringing an activity to the group if they wish and staff can also just pop in for a few minutes. Senior managers advised that the group is quite well attended and promotes conversations between colleagues who may not usually work side by side such as the administration and nursing team.

Staff also spoke positively of the weekly scenario based learning sessions. Senior managers advised that these provide a space for experiential learning based on current topics. These can also be utilised to focus on current themes from the unit or specially requested topics, and one session per month is dedicated to staff wellbeing. We can see in evidence provided that other themes have included, child protection supervision, labels and presumptions, and faith and religion. There are also regular journal clubs where a staff member selects a relevant article to present.

Support of new staff, including newly registered nurses can be directly linked to staff retention and health and wellbeing. Evidence provided includes the general staff and medical staff welcome information booklet for the Dudhope Unit. These describe the layout of the unit, fire safety, electronic systems access and breakdown of unit meetings. The general information booklet also describes the learning from excellence scheme. This enables staff to nominate their peers to recognise areas of good practice. We were also provided with the Dudhope Unit nurse induction pack and NHS Tayside induction and orientation policy. These include information such as roles and responsibilities, allocation of mentors and timelines for reviews such as at the end of the first week. The nursing induction includes review of general policies and procedures, including child protection guidelines, fire policies and procedures, record keeping and medication. The document highlights that for the first week of induction new staff members will work shifts but will be supernumerary and in the second week will work shifts as much as possible alongside their mentors. The key objectives for the second week are to become familiar with operational aspects of the clinical environment and to have increased patient contact.

As discussed earlier in this report we observed positive feedback relating to the student nurse induction process. Evidence provided includes the Dudhope Student Nurse Induction Procedure. This includes required tasks such as allocating practice supervisors and assessors, a pre-placement phone call and local induction. All student nurses get a full day's induction to the unit; we were provided with the slide show presentation for the day. This includes information about the unit, fire safety, health and wellbeing resources, mealtime management and resources regarding eating disorders.

Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is to enable clinical leaders to ensure they have protected time and resource to ensure appropriate staffing alongside other professional duties to lead the delivery of safe, high quality and person-centred healthcare. Part of the senior charge nurse role includes leadership, overseeing quality and safety and development of their team including annual appraisals. We did not have the opportunity to speak with the senior charge nurse for the unit during our onsite visit/inspection to discuss provision of adequate time to lead. However, we can see in evidence provided that appraisal rate completion for nursing staff is 85%. We can

also see that completion rate for medical and psychology staff is 100%, with administrative staff due to be 100% by the end of November 2025. Whilst completion rates are lower for the allied health professional team, senior managers advised that dates have been set to complete outstanding appraisals.

We were advised of staff development days that take place twice yearly to capture as many staff as possible and include training, team building and information training. Past days have included training on borderline personality disorder and information sharing in relation to the "Hello my name is initiative" The "Hello my name is" campaign encourages NHS staff to introduce themselves to their patients to build trust, relationships and compassionate care.

Staff told us that the unit does not have regular all-staff meetings, but that information is shared via email or safety brief depending on content of information. We discussed this further with senior managers who advised that due to the number of staff working shifts it can be difficult to facilitate meetings to which all staff can attend. They also confirmed that information is shared via the unit daily safety brief document, email and shared online channel. As discussed earlier in this report the unit provides clinical supervision and reflective practice which is available for all staff.

As previously discussed, we asked NHS Tayside to provide us with incidents reported by staff for the six months prior to this inspection. We can see from these that there was a total of 670 recorded incidents in this time span. We recognise that a high number of reported incidents/near misses can indicate a culture of transparency and openness to enable lessons to be learned and promote a safe delivery of care. An increase in reported incidents may also be attributed to the acuity and dependency of the young people on the unit at the time.

Adverse event reviews help to identify whether the potential harm, or actual harm associated with the adverse event was avoidable. The Healthcare Improvement Scotland A national framework for reviewing and learning from adverse events in NHS Scotland highlights the expectations, guidance and timeframes for adverse event reviews. See [here](#) for further information. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. Significant adverse event reviews are essential to ensure key learning and reduce the risk of future harm. We can see in evidence provided there were no incidents assessed as requiring a significant adverse event review for the Dudhope Unit in the past 12 months.

Senior managers advised that they have oversight of incident reports submitted and they are reviewed at the monthly incident report review meeting. Evidence provided includes the minutes of the October meeting. These include the number of total incidents with or without harm. Any identified themes are discussed with outcome of review and actions to be taken. Identified themes in the minutes include error with meal provision and medication errors. Outcomes and actions include a meeting to be arranged with catering and dietetics and the development of further education for nursing staff relating to medication. We observed three incident reports submitted in the six months prior to our inspection where the wrong dose of medication had been administered. It is not documented in these that they had resulted in any harm to the young people. We can also see that actions include recording physical observations and informing duty medical staff, the young person, and their carer. Staff also advised us that the unit has recently implemented that all medication is checked and signed by two members of staff.

Senior managers advised that oversight of incident reports are also included as part of wider clinical governance. We were provided with the clinical governance meeting report for the Dudhope Unit for August and September 2025. These reports are presented at the NHS Tayside women, child and families governance meeting. Risk management and adverse event management are included in the report. It is highlighted in the executive summary that there had been a significant increase in incident report submissions due to acuity and dependency of young people on the unit. It also highlights that the majority of the incident reports relate to the use of restraint for the administration of artificial nutrition via nasogastric tube and that best practice guidance is currently being developed. Nutrition via nasogastric tube and restraint will be discussed later in this report.

We can see that of the 670 incident reports submitted in the six months prior to this visit/inspection, all apart from one have been reviewed and approved and have the level of review required documented, such as team based discussion/review or no review required. The remaining one incident was submitted at the end of September and whilst it had not been approved it was under review.

Pathways, procedures and policies

We observed staff responding to young people's needs, staff and patient interactions were warm and respectful, and the ward felt calm and well organised. We observed that there is a board planner in the staff duty room which the nurse in charge completes. This includes names of staff on shift and allocated roles such as who is supporting mealtimes and who is the floor nurse. Part of the floor nurse role includes keeping a visible presence on the unit to provide awareness of where young people are to ensure safety and responsiveness of care. We observed a poster detailing floor nurse guidance. This highlights that the floor nurse should be clearly identified on the planning board. Key roles include, but are not exhaustive of, visibility and availability, awareness of the location of each young person, and being a protected role for example would not be allocated to complete medication rounds. We observed that the floor nurse for the day was handed over at the rapid rundown. We also observed that the board planner included review dates for young people's care plans and which staff were responsible for completing them.

The provision of meaningful activity on mental health wards is said to increase social connectedness, improve psychological wellbeing and is essential to promote wellbeing and recovery. We observed a timetable of activities displayed in the unit which included school times and therapeutic activities. We can see in evidence provided that timetabled activities include relaxation groups, music group, cooking sessions and decider skills. The young person's welcome pack for the unit includes a detailed online deciders skills information resource. This explains that the deciders skills group is run every Tuesday and teaches skills based on a cognitive behavioural therapy approach to help young people to recognise their thoughts, feelings and behaviours to enable them to monitor and manage their emotions and mental health. During our onsite visit/inspection we were able to attend a decider skills session. This was person centred, included warm and positive interactions and appeared well received.

Senior managers advised that there are twice weekly community meetings where young people can share what activities they would like. From Monday to Friday the occupational

therapist and AHP Assistant Practitioners coordinate activities during daytime. Where able, they will align activities to the young person's preferences including consideration of what is available in their local area once discharged. Available activities include mindful movement with the physiotherapy group or activities in the gymnasium, music groups and art groups. During our onsite visit/inspection staff told us that young people were currently developing the scenery for the Christmas pantomime. We were also advised that activities include trips to the Victoria and Albert museum, local parks and libraries. Staff did highlight that whilst there was less to do in the evenings this had improved with the introduction of the evening "check in". These are discussed later in this report.

Staff told us there are no planned activities at the weekend and that these are more ad hoc and provided by the nursing staff. These can include self-care activities, walks, planned outings and support time. Support time is discussed further earlier in this report and includes available resources for activities such as quizzes, word searches and self-care activities. There is also an available online resource for distraction and self-care ideas. This describes that young people may find distraction techniques can be helpful to focus attention away from feelings of anxiety, panic or distress. The resource has a large number of suggestions for distraction and self-care including such things as spending time in the sensory room, singing, reading a book, listening to a podcast or writing a letter to a loved one.

The Commission discuss the availability of therapeutic activities earlier in this report.

Restraint

Physical restraint should only be used as a last resort to prevent a person from harming themselves or others, or to provide necessary help or treatment. The Commission highlights that physical restraint should only be implemented by staff who have been fully trained in the methods of restraint. Physical restraint training supports staff in how to apply techniques safely without causing unnecessary harm or distress. We can see in evidence provided that 86% of staff at the Dudhope Unit have completed online prevention and management of violence and aggression training. It is documented that all nursing staff are required to complete face to face, three day training which includes restraint, with training compliance at 61%.

We asked senior managers for an update on this who advised that face to face training was due to be provided on the unit in November 2025 but had to be rescheduled to 2026 due to unforeseen circumstances. We can see in updated training compliance data that training compliance has improved for both online and face to face training with the latter being at 74%. Senior managers advised that the charge nurses and senior charge nurses monitor required skills when completing the nursing rota to ensure adequate staff on duty have prevention and management of violence and aggression skills. We did not see any incident reports submitted in relation to lack of available staff with prevention and management of violence and aggression skills. Whilst we recognise an improvement in training compliance a requirement has been given to support ongoing improvement in this area.

Nutrition via artificial means and mealtime support

Scottish Child and Adolescent Mental Health Services have reported an unprecedented increase in the number and severity of young people presenting with eating disorders since the

start of the COVID-19 pandemic. More information can be found at [Eating Disorders in Scotland](#).

The Royal College of Psychiatrists medical emergencies in eating disorders: guidance on recognition and management highlights that eating disorders can present with life threatening emergencies and that weight loss in children and adolescents is often more acute due to lower body fat stores. The guidance highlights that some people may resist weight gain by any means and compulsory treatment under the relevant legislation may be necessary, especially in cases where the level of malnutrition is life threatening. This may require insertion of a nasogastric tube against the patient's will, by staff trained in safe hold techniques to enable the administration of nutrition via the nasogastric tube.

The Mental Welfare Commission's good practice guide for nutrition by artificial means highlights that the Health (Care and Treatment) (Scotland) Act 2003 makes specific reference to the provision of nutrition by artificial means in the absence of consent. More information can be found [here](#). SIGN guidelines (2022) for eating disorders documents that "clinicians should consider whether the Mental Health (Care and Treatment) (Scotland) Act 2003 needs to be invoked when a patient (of any age) declines treatment: There may be a responsibility to provide compulsory treatment if there is a risk to the person's life or to prevent significant deterioration to health and wellbeing. Scottish Intercollegiate Guidelines Network (SIGN), aim to improve the quality of health care by reducing differences in practice and outcome.

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 documents when treatment may legally be given to patients who are not capable of consenting to treatment. As part of our joint visit/inspection to Dudhope Unit the Commission reviewed young peoples' care records in relation to the legal authorisation of treatment as noted earlier in this report.

Evidence provided includes the Dudhope Young Peoples Unit, provision of nutrition via artificial means (including under restraint), good practice guidance. This explains that the guidance is for all involved in the care of a young person (12-18) with an eating disorder, disordered eating or significant risk of malnutrition associated with food and/or fluid refusal/restriction. It is documented that it should be read alongside a number of other guidelines and policies including the Mental Welfare Commission good practice guide – nutrition by artificial means. It documents a number of underlying principles including person centred compassionate and trauma informed care, and a rights based least restrictive approach. Trauma informed practice includes recognising where people are affected by trauma and responding in ways that prevent further harm. We can see in evidence provided that 81% of staff have completed trauma informed practice training with a further 61% having completed enhanced level training.

We can see that it is documented in the Dudhope Unit clinical governance report in October 2025 that the majority of incident reports submitted relate to the utilisation of restraint to administer artificial nutrition via nasogastric tube. It also documents that best practice guidance in line with NICE guidelines, SIGN guidelines and Mental Welfare Commission guidelines are currently in development for the administration of nutrition via artificial means to ensure practice is trauma informed, person centred, rights based and least restrictive. It is also documented in the Dudhope Unit mealtime management group meeting minutes for September 2025 that the guidance is under development. Standing items of the mealtime management group meetings include, but are not exhaustive of, catering, stock, meal plans, pre meal activity/support, post mealtime support and staff training. Outcomes and actions are

also documented in the minutes such as checking storage requirements for certain stock.

We observed four reported incidents where young people had received the incorrect volume of nutrition via nasogastric tube. Senior managers advised that errors relating to the administration of nutrition via nasogastric tube are discussed by the senior nursing team with a focus on themes and any training or learning requirements. We were also advised nursing staff had completed written reflections to assist in learning from the incident. Actions from another incident included re writing the meal plan to provide further clarity.

Dudhope Unit utilise a nasogastric tube position record. This includes space to record date and time of administration, length of tube, amount of nutrition and PH of aspirate. Aspirate should always be obtained from the nasogastric tube prior to commencing nutrition to ensure correct placement in the stomach. Within evidence we observed two incident reports which documented the nasogastric tube position chart did not include safety checks or amount of nutrition given. We raised this with senior managers who advised senior nursing staff had been alerted to the omissions in the charts and a reminder for accurate recording was added to the daily safety brief document. A nightly audit of nasogastric documentation is also now undertaken by night staff. A requirement has been given to support improvement in this area.

During our onsite visit/inspection we observed that there is a folder in the treatment room containing young people's nasogastric tube position records. Staff told us that nutrition via nasogastric tube is administered either on a specific type of chair or patient trolley. However, the trolley is currently not in use as it's faulty and a new one is waiting arrival. Senior managers advised that prevention and management of violence and aggression instructors have advised staff on how to utilise safe restraint on the available chairs.

We can see in evidence provided 72% of staff have completed competencies for the insertion and care of nasogastric tubes. We asked senior managers how they ensured there were enough available staff on duty who are competent in the insertion and care of nasogastric tubes. We were advised that the senior charge nurse and charge nurses review rostering requirements when completing the roster. We were also advised this is monitored via the real time staffing system and included in the twice daily professional judgment tool and any concerns are raised for immediate review and action. We did not see any incident reports relating to lack of available staff trained in the insertion and care of nasogastric tubes in evidence provided.

Dudhope Unit has protected mealtimes and families/carers are asked, where able, not to visit during these times. It is described that this is to enable staff to provide support during mealtimes. A young person may require mealtime support as part of their planned care. We were provided with the standard operating procedure for meal management of young people with an eating disorder. This includes times for meals and the steps to be taken before, during and after mealtimes such as post mealtime support. Senior managers advise that nursing staff receive meal support training as part of induction. We were also provided with the QR code for the staff online mealtime management resource which is used for training. This describes that mealtimes are protected and where able, all other nonessential activities should stop. It also provides guidance on what may be helpful before, during, and after meals and links to various other online resources such as BEAT eating disorders charity. BEAT is a nationwide organisation that provides support to people affected by eating disorders, their friends and families.

We observed two incident reports where specialist diets for young people had not been

received on the catering trolley. We raised this with senior managers who advised all incidents relating to provision of dietary requirement will be reported to and discussed with the catering manager. It is also documented in the incident forms that the catering department had been contacted and alternative diet provided.

Stress and distress can include agitation, anxiety and aggression. We noted completed Antecedent – Behaviour – Consequence (ABC) charts in the staff duty room for two young people. ABC charts are used to identify triggers of stress and distress by recording events prior to, during and after an event. Staff advised that each patient would be considered for an ABC chart if there was evidence of behaviours that could cause the young person further stress and distress. Completed charts are reviewed by the psychology team and discussed at the young person's multidisciplinary team meeting to help staff identify and, where able, prevent further stress and distress. The outcome of which will be included in the young person's care plan.

Staff told us that the unit has recently implemented the Safewards model. This recognises staff and patient modifiers that can have an impact on the rates of conflict and required interactions such as seclusion, medication and safe holds. The Safewards model highlights 10 interventions that can reduce rates of conflict. These include, but are not exhaustive of, clear mutual expectations, positive words and reassurance. The utilisation of the 10 Safewards interventions has been shown to reduce the incidents of conflict and containment. We observed that the "you said we did" board had a question relating to what the Safewards model is. This described it as a model to keep everyone as safe as possible by focusing on ten interventions. There was also a QR code which can be scanned for further information.

Evidence provided includes the Dudhope Unit Safewards progress report. This describes that there were three training sessions for staff provided over two weeks. There was also individual and small group meetings to discuss the model and implementation plan. There is a Safewards electronic platform for all staff including sub channels for each of the ten interventions. It was agreed that the implementation of the model would start with five interventions first. These included discharge messages, positive words, know each other, talk down and clear mutual expectations. Staff were asked to consider if they wanted to lead or be part of the working groups for each intervention. Working groups were then set up for each intervention with initial ideas and actions allocated. Ongoing work so far includes the development of a staff "yellow pages" which will gather information about staff members roles and interests and "getting to know our young people folder". This will provide an overview of the young people on the unit and their personalised resources such as safety plans, care plans and fizz scales. A fizz scale is part of the decider skills and is a 0-10 tool to measure the intensity of strong emotions to enable young people to recognise the physical signs of build-up of emotions. Evidence provided includes blank copies of the fizz scale documents that young people complete. These include sections to complete next to each score such as what it feels like, what makes them feel this way and what the young person and others can do to help.

Approximately 0.7% of reported incidents relate to staff having to intervene to stop or prevent young people from assaulting other young people. Documented actions include discussion with the multidisciplinary team, notifying the young person's family and commencement of continuous interventions. We were also provided with evidence in relation to one incident that highlights police were contacted and public protection measures followed. We asked senior managers how young people are supported if they are involved in, or witness stress and

distress. We were advised that during ongoing incidents young people who are not directly involved will be supported by staff to move to another area when possible. During this time distraction activities will be offered such as music or art therapy. After incidents of stress and distress young people will be offered a 1:1 session with the nursing or multidisciplinary team. Staff also told us of the development of debrief sessions for young people and we observed posters describing debrief in the unit including in the bedrooms. These documents that debrief is a calm and supportive conversation to discuss what has happened, how it could have been done differently and how staff can help young people feel safe and supported.

Young people are supported to utilise the Dudhope check in activities online resource. This provides young people with multiple alternative ways to describe how they are feeling if they find discussing their feelings difficult. These include “what emoji describes how you feel today”, “what do you need today”, “tell me something that made you smile today” a mood thermometer and “what Taylor Swift song describes how you feel today”.

Approximately one percent of incident reports submitted as evidence relate to young people being administered intramuscular sedation due to significant stress and distress and to administer treatment. Further documentation includes if oral sedation had been offered and declined and if distraction techniques had been tried. Evidence provided includes the good practice guidance on pharmacological management of acute behavioural disturbance in young people aged 12-18 years, which is utilised by the Dudhope Unit. This describes that every effort should be made to utilise nonpharmacological interventions to de-escalate where able and that if safe to do so, oral medication should be used first. If there is no response to oral medication, a young person refuses it, or level of stress and distress is such that precludes oral medication then intramuscular medication may be administered.

The good practice guidance records the physical observations and monitoring required following the administration of intramuscular medication. This includes when to seek medical advice such as in the case of reduced respiratory rate. It was not clear in all incident reports relating to the administration of intramuscular sedation if physical observations had been recorded. However, these may have been recorded in the young person’s care records including physical observation chart. The unit records young people’s physical observations on the CAMHS Early Warning Score chart. This provides a score depending on the young person’s physiological parameters such as heart rate and respiratory rate to improve the detection and response to those who are at risk of becoming or have become more unwell. The chart documents actions to be taken depending on the calculated early warning score including timeline to repeat observations, escalation to senior medical staff and calling 999 in emergencies.

We asked senior managers how young people’s physical health is monitored. We were advised that all young people who are admitted to the unit have a physical examination including blood tests and an electrocardiogram. Repeated blood tests may be required for certain young people including those with an eating disorder and those on certain anti-psychotic medication. Any physical concerns will be handed over at the rapid rundown or escalated to the on call psychiatric medical team. In the event of a medical emergency staff will follow the NHS Tayside summoning clinical assistance policy and contact 999. We were provided with a number of policies and pathways relating to physical health. These include the physical health monitoring form and the medical emergencies in eating disorders (MEED) risk assessment chart. This is

aligned with the Royal College of Psychiatrists medical emergencies in eating disorders: guidance on recognition and management. For further information see [here](#).

The Quality Network for Inpatient (CAMHS) Standards for Services (Royal College of Psychiatrists) standard (2.3.3) documents that all medical and registered nursing staff that administer rapid tranquillisation should complete immediate life support training or a local equivalent. Immediate life support training teaches more advanced skills than basic life support training including airway management. We can see in evidence provided that whilst all medical staff have completed immediate life support training, no nursing staff have completed it. We can also see that basic life support training compliance is 69% for registered staff and 38% for health care support worker staff. A requirement has been given to support improvement in this area.

We asked senior managers how they ensured there are enough available nursing staff on duty who have completed basic life support training. We were advised that the senior charge nurse and charge nurses review rostering requirements when completing the roster. We did not see any incident reports submitted in relation to medical emergencies.

Self-harm

The National Institute for Health and Care Excellence (NICE) defines self-harm as intentional self-poisoning or injury, irrespective of the apparent purpose. Scotland's self harm strategy and action plan (2023-27) highlights that self-harm is complex and varies widely from individual to individual and can serve a variety of functions. These can include a form of self-punishment, compulsive or habitual behaviour and distraction from distressing emotions. It also documents that self-harm can enable people to regulate emotion, provide release or comfort and restore calm.

Approximately 18% of incident reports submitted as evidence relate to staff having to intervene due to young people attempting to harm themselves. We can see from documentation in incident reports that it appears staff responded appropriately and intervened, including escalating for medical help and further medical assessment and treatment when required. Approximately 65% of these incidents relate to young people tying or attempting to tie ligatures. We can see that it is documented that when required staff used ligature cutters to remove these and observations and physical checks were completed. During our onsite visit/inspection we observed that there is a ligature box including ligature cutters in each duty room. We were also advised that this is discussed at staff induction. Staff were aware of the annual ligature risk assessments and advised outcomes were cascaded to them. We observed that there were anti ligature fittings throughout the ward such as curtain rails and shower curtains. Senior managers also advised that the paper towel dispensers used in the bedrooms are held in place magnetically and designed to detach when weight is applied. Evidence provided documents that these were tested in November 2025 and no issues identified.

Staff advised the bedroom doors have alarms which are activated when weight is placed on them. We were also advised that the alarms are tested weekly by the staff to ensure they are in working order. We observed one incident report where it is reported that during maintenance of the door that it was found that the alarm was not working and required an electrician. It is also documented that this was escalated to the senior nursing staff, room

locked and communicated to the team that the room was not to be used until the alarm was repaired. Evidence provided includes the instructions/protocol for how to undertake the weekly door checks and template for recording the test. During our onsite visit/inspection we observed that the record chart for testing the doors was complete and up to date.

Annual ligature risk assessments are part of an ongoing programme of assurance within NHS hospitals to reduce the number of incidences of self-harm or suicide by identifying potential ligature points and the controls and mitigations in place to reduce identified risks. The NHS Tayside mental health and learning disabilities services protocol on environmental ligature risk reduction outlines a standardised approach to the identification and management of environmental ligature risks. The protocol provides guidance on how to complete a ligature risk assessment including ligature anchor point risk assessment tool scoresheet. The score sheet formulates a red, amber or green risk score depending on a number of factors including, room area, patient profile, compensating factors and likelihood of incident. The protocol describes that only red and amber risk are included in the general risk assessment.

Evidence provided includes a completed ligature risk assessment scoresheet for the bedrooms for the unit and also the general health and safety risk assessment for the unit. We can see that both of these have been completed within the past 12 months. The health and safety risk assessment documents red and amber rated risks and any existing control measures. These include personal risk assessments and care and treatment plans. We asked senior managers how green risks are mitigated who advised that all staff are aware of green rated risks and these are mitigated as part of general ward management. This includes the designated floor nurse completing regular walk rounds of the unit to identify any changes or developing concerns. Where necessary further risk assessment will be undertaken including individual risk assessments for young people. Risks identified are communicated through safety huddles and daily briefings and documented in the young person's care records.

We can see in evidence provided that several incidents are reported due to staff having to intervene to prevent young people from absconding from the unit. These include several where it is documented that the NHS Tayside missing persons policy had been implemented including contacting the police as a young person had absconded from the unit and grounds. The missing persons protocol includes actions to be taken by staff including contacting police, escalation to the duty manager and completing an incident form. Documentation in reported incidents include when police, family and senior managers were informed. We asked senior managers for further information on these incidents. We were advised that any attempts or successful attempts to abscond from the previous day are discussed with the multidisciplinary team at the morning rapid rundown. This includes reviewing any mitigations that are in place or required to be put in place including implementation of continuous interventions or locked door policy with consideration of least restrictive practice. We observed that continuous interventions and the requirement to utilise the locked door policy was discussed at the rapid rundown including any mitigations that could enable least restrictive practice.

Continuous interventions

Continuous intervention is an enhanced level of care implemented when a patient has elevated levels of risk that cannot be mitigated without continuous, supportive intervention. It should be specific, therapeutic and purposeful, as least restrictive as possible and in line with the

patient's needs. Within a number of the incident reports we reviewed, continuous interventions had been implemented to mitigate risk including the risk of self-harm and absconding. We were provided with NHS Tayside's mental health and learning disabilities observation protocol. This advises that the protocol has been influenced by the 2018 guidance from Healthcare Improvement Scotland (HIS) 'from observation to intervention'. For more information please see [here](#). This aims to support mental health practitioners to move away from the traditional practice of enhanced observations and work towards a patient centred, responsive proactive care.

The protocol describes two levels of intervention: general care which is the level of care all patients should receive regardless of presentation and/or risk, and continuous interventions when a patient requires the continuous, supportive presence of a member of staff. Continuous intervention should be as least restrictive as possible, therapeutic and aligned with the young person's needs and reviewed regularly. As part of their training in continuous interventions staff complete a written reflection of their understanding of both the NHS Tayside observation protocol and Healthcare Improvement Scotland (HIS) from observation to intervention piece describing their understanding.

The unit utilises a continuous intervention record sheet which includes date and time commenced and discontinued, if care plan has been updated, intervention taking place and effectiveness of intervention. In addition, there is an observation sheet that consists of a red, amber, green (RAG) rated scoring system to highlight the young person's current presentation and interventions to be considered. This includes such things as encouraging to engage in therapeutic activity and distraction/coping strategies if young people appear tense, withdrawn or showing signs of stress and distress. It is highlighted on the chart that immediate intervention is required, and the nurse in charge should be informed if the young person is observed to be experiencing high levels of stress and distress such as high risk behaviours.

We observed that it is documented on the daily safety brief document if any young people are on continuous interventions including the date they commenced. This was also discussed at the morning rapid rundown.

Seclusion

The Mental Welfare Commission use of seclusion good practice guide documents that it should only be considered when the person is a significant danger to others, and the situation cannot be managed by any other means. Please see [here](#) for further information. We were provided with the NHS Tayside inpatient mental health and learning disabilities system wide seclusion and long term seclusion protocol. This describes two levels of seclusion. Level one, where a person is locked alone in a room or suite of rooms or where staff place a person in a room and prevent them from leaving. Level two seclusion includes where staff remain with the person in a room or suite of rooms and prevent them from leaving or place restrictions on the physical environment to keep them separated from others. The policy highlights that seclusion should only be implemented as a last resort when all other interventions have been attempted and failed or have been deemed to be unsafe. It further documents that the decision to implement seclusion must be made by either a member of the medical team or nurse in charge of the ward and responsible medical officer or duty responsible medical officer if out of hours must be informed. The seclusion protocol includes a seclusion prescription sheet to document the

reason for seclusion and observation/review chart. The observation/review chart should be completed at a minimum of every 15 minutes during seclusion by the member of staff monitoring the young person during seclusion including documenting the young person's physical as well as mental wellbeing.

We did not have the opportunity to review any care plans or documentation relating to seclusion during our onsite visit/inspection. However, the Commission reviewed all young people's documentation; please see earlier in this report for further information.

Of the incident reports submitted in the six months prior to this inspection, four related to seclusion. We can see that it is documented in the incident reports that this was discussed with on call medical staff and duty managers and that seclusion was implemented to maintain the safety of the young person and other young people in the unit. It is not documented in all incident reports how long seclusion was in place for or if family contacted. However, this may have been documented in the young person's care records.

Documentation

During our onsite visit/inspection we observed that the unit utilises both paper and electronic care records. Care plans we were able to observe were comprehensive and we noted evidence that interventions were person centred and individual, with social stories being utilised to plan for interventions such as having bloods taken. Social stories provide short, clear information about new or difficult situations to help reduce stress and distress. We also observed a "nightly check in" with young people which documented any positives or challenges from the day. This was in a format that was person centred and accessible.

The Mental Health (Care and Treatment) (Scotland) Act 2003 emphasises patient rights, participation in decision-making, and person centred care. Evidence provided includes the NHS Tayside mental health and learning disability nursing standards for person centred care planning. This describes that the standards provide a framework to support the development of person centred care planning and includes a number of standards and guidance to meet them. These include but are not exhaustive of what is important to the person is identified, goals should be realistic and attainable, and the care plan will demonstrate involvement of the person. Staff and senior managers advised that the unit completes monthly audits of five young people's care plans.

The care plan audit includes 12 standards each with specific questions relating to person centred care. These include if a young person has continuous interventions in place, is there a care plan in place, and if so, does it evidence tailored therapeutic interventions. It also includes if there is evidence of young person and family/carer involvement and if they have been provided with copies of the care plan.

We were provided with an overview of the scores of the care plan audits from April 2023. We can see from this that the audits have scored above 93% since July 2024 with the latest score for September 2025 being 98.8%. We can see in the data included in the September audit that two of the care plans audited had a score of 96%. This is due to one young person's family/carers not being given a copy of the care plan and agreed interventions not having evidence of past support measures. However, we can see that it is documented that past supportive measures had not yet been identified. Senior managers advised that feedback of

areas of good practice and areas for development from the audits are shared with the nursing team either verbally or via email including any themes or trends.

Outdoor spaces in mental health wards play a crucial role in patient wellbeing, recovery, and overall therapeutic care. The Dudhope Unit has a well maintained courtyard garden which can be accessed from the residential unit. We observed young people requesting to go outside which was facilitated by staff. The Dudhope Unit is set in open grounds including wooded areas. During our onsite visit/inspection we observed young people watching a family of deer who were feeding close to the windows. Staff advised that the deer can regularly be seen from the unit.

Care environment and infection control and prevention

Standard infection control precautions such as linen, waste and sharps management and maintenance of the care environment minimise the risk of cross infection and must be consistently practiced by all staff. We observed that linen and sharps bins were stored and managed in line with guidance with waste and used sharps boxes stored in a secure bin out with the residential unit. Cleaning products were stored securely and we observed a locked box on the domestic trolley for transportation of hazardous substances throughout the ward.

Domestic staff we spoke with described feeling supported, able to raise concerns and listened to and that they enjoy their work. We were also told that domestic staff carry personal alarms and nursing staff provide them with a daily safety briefing and updates if required. We asked senior managers what support was provided to domestic staff if they witness young people experiencing stress and distress. We were told that senior managers maintain regular contact with domestic staff and will contact the domestic supervisors to advise if there have been any incidents where staff may need support. Domestic staff are also able to access NHS Tayside staff wellbeing service and meet with the unit chaplain. Senior staff in the unit introduce themselves to domestic staff at their induction including providing advice on how to raise any concerns.

We observed that the ward was clean and uncluttered and in general in good repair other than as previously mentioned fire door faults. We also noted that there was a split piece of wood on one fire door causing a sharp piece of wood. We raised this at the time and it was resolved straight away. We also observed an area of damaged flooring which had been repaired with tape which may make effective cleaning difficult. We raised this with senior managers who advised that this has been reported to NHS Tayside estates department and is awaiting repair. However, we were not provided with a timeline for this.

The Dudhope Young People's Inpatient Unit windows include a metal mesh on the inside of one side of the windows to enable them to be opened whilst reducing ligature risk and the risk of absconding. Whilst we observed that the majority of the environment was clean and well maintained, we observed that the window meshes had dirt in them. We also noted that there were numerous dead spiders in the light fittings in some of the bedrooms and corridors that could easily be seen as the light fittings are clear. We raised this with senior managers at the time of the inspection and have since been advised that both the window grills and light fittings have been cleaned. A requirement has been given to support improvement in this area.

Dignity and respect

We observed that all young people were treated with dignity and kindness, and we observed compassionate interactions between staff and patient's carers.

The Dudhope Unit welcome information for young people documents that on admission each young person will be introduced to their nursing team which consists of a charge nurse, key worker and four other nursing staff. The nursing team will work with the young people to develop their care plans. It is also highlighted that an early care plan meeting will be arranged within the first week of admission. During our onsite visit/inspection senior managers advised that daily 1:1 time is offered to young people by their nursing team. We did not have the opportunity to speak with any young people during our onsite inspection. However, as part of their methodology the Commission spoke with several young people including in relation to person centred care. Please see earlier in this report for further information.

Evidence provided includes the Dudhope young persons autism spectrum disorder/sensory environment – monitoring, audit and development work for November 2024. This was a collaboration between occupational therapy, speech and language therapy and young people to make improvements to the unit environment for those with autism spectrum disorder and sensory needs. Improvements from this include young people choosing the colour of the sofa covers in the wellbeing room, board with photographs of nursing staff being implemented and review of lighting. Senior managers also advised that there will be another audit completed in November 2025.

Evidence provided includes the patient use of personal mobile phones local protocol for the Dudhope Unit. This documents that young people are permitted to bring their own mobile phones into the unit as this enables communication with families and friends, access to music and educational resources and therapeutic technology. However, it also highlights that the use of mobile phones can be intrusive and those with camera and sound recording capacity have significant potential to impact on privacy, dignity and patient confidentiality. Young people are not allowed to bring in their own power banks, chargers or cables. Mobile phones are charged overnight in the nurses' duty room.

We can see in evidence provided that there has been an episode where a young person had uploaded a video to a social media platform. This featured the sound of a young person experiencing stress and distress and also a member of staff's voice. Senior managers advised that the young person was asked and agreed to delete the recording from the platform. We were also advised that the young person in the recording was not identifiable.

Evidence provided includes NHS Tayside system wide mental health and learning disabilities locked door protocol. This describes that limits to an individual's freedom should only be considered when their health, safety or wellbeing or that of others is at risk. The protocol includes notices that should be put in place if the locked door policy is in use. During our onsite visit/inspection staff advised that the locked door policy was in place due to current risk. We observed that this was discussed at the rapid rundown and also documented on the safety brief, and notices were in place and advising to ring the bell to enable access. We can also see that it is documented in the clinical governance meeting in October that the locked door protocol had been activated to ensure patient and staff safety. The Commission was satisfied with this approach which was regularly reviewed and subject to dynamic, ongoing risk

assessment.

Mixed sex accommodation can have an impact on dignity and personal choice. All bedrooms in the Dudhope unit have ensuite bathrooms. There is also one main communal area and two smaller lounges, senior managers advised that the smaller lounges can be utilised to be a single sex area. Staff also told inspectors that they are mindful of which bedrooms young people are allocated to help respect their privacy.

Summary of joint findings by the Mental Welfare Commission and Healthcare Improvement Scotland.

Areas of Good Practice

1. Young people and their families reported positively on staff support and all observed actions between staff and young people were noted to be encouraging and compassionate.
2. Parents and carers felt involved, included and that their views were sought and considered. They had confidence and trust in the clinical team.
3. There was development and implementation of age specific accessible sibling leaflets.
4. Safeguards were in place to ensure lawful treatment under the Mental Health Act and Adults with Incapacity Act.
5. We heard about a well-functioning team approach where there was mutual respect for roles and differences of view which were heard, considered and agreements reached.
6. Provision of information leaflets for young people and families and their carers who are admitted to the unit from out of area.
7. Link charge nurse has developed multiple detailed online information resources for staff, young people and families/carers.
8. Unit rapid rundowns were concise, person centred, structured, inclusive and included members of the multidisciplinary team.
9. Feedback committee meetings including action log to record feedback from various sources.
10. Discharge core group meetings to highlight good practice and areas for improvement.
11. Staff attendance at a transformational practice development course leading to introduction of the "Pot Luck Pass Times" group to maintain and build staff relationships.
12. The school, its staff and leadership were an integral part of the Dudhope team. There were no restrictions on access to education, irrespective of the young person's home local authority or if they were still on a school roll in their local area – we were told the young people got access to whatever level of education they needed.

Areas for improvement

1. Key clinical information around significant events, such as restraint, was not being recorded adequately in clinical records. This is a significant risk and recording expectations needs to be addressed with regular audits done for assurance.

2. There has been a long-standing lack of dedicated social work input to the unit, timelines need to be set and met to address this gap.
3. We were unable to view multidisciplinary risk assessments during our visit. Multidisciplinary risk assessments should be in situ and readily accessible. Risk assessments should inform comprehensive risk management plans to address complexities identified. Audits require to be done to give assurance of consistency of approach to risk assessments and comprehensive risk management plans in response to all identified risks.
4. There was no promotion of advance statements. It is recommended that Dudhope build the offer of an advance statement into practice when the person is well, as part of discharge planning.
5. We observed there were significant delays in maintaining the health care environment including maintenance of fire doors and completion of fire risk assessment actions. Action needs to be taken to address this.

Requirements

The following requirements have been made which NHS Tayside must prioritise to meet national standards.

- **NHS Tayside must ensure all staff have completed appropriate levels of child protection and adult support and protection training relevant to their roles (see page 23).**

This will support compliance with: NHS Public Protection Accountability and Assurance Framework (2022) and Health and Care (Staffing) (Scotland) Act (2019).

- **NHS Tayside must ensure all improvement actions within fire risk assessments are completed within required timeframes and portable fire equipment is tested as per guidance (see page 25).**

This will support compliance with: NHS Scotland "Firecode" Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006), and Quality Assurance System: Quality Assurance framework criteria 2.6, 6.7).

- **NHS Tayside must ensure effective systems and processes are in place to support assurance of a safe healthcare environment and that all essential maintenance works are completed in a timely manner (see page 26).**

This will support compliance with: Quality Assurance Framework (2022) criteria 2.6, 4.1, 6.1, 6.7 and Health and Social Care Standards 2017 criterion 5.17 and 5.22.

- **NHS Tayside must ensure staff are provided with adequate training to safely carry out their roles including that all staff who administer rapid tranquillisation have completed immediate life support training or equivalent (see page 38).**

This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Quality Assurance Framework (2022) Indicator 2.14 and 6.1 and Quality Network for Inpatient CAMHS Standards for Services (2021) Criteria 2.3.3. and The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2018) and relevant codes of practice of regulated healthcare professions.

- **NHS Tayside must ensure all young person’s care documentation is accurately and consistently completed and reviewed appropriately. This is to include accurate documentation and administration of artificial nutrition via nasogastric tube (see page 40).**

This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.2, 6.1, 6.2, 6.6 and Health and Social Care Standards (2017) 2.21 and 2.22.

- **NHS Tayside must ensure the healthcare environment is effectively maintained to ensure a clean and safe environment (see page 42).**

This will support compliance with: National Infection Prevention and Control Standards (2022) and Quality Assurance Framework (2022) criteria 2.6 and 6.7.

Next Steps

A requirement in the inspection report means the hospital or service has not met the required standards and that we are concerned about the impact this has on patients using the hospital or service.

We expect NHS Tayside to address all of the recommendations and the requirements in this report. The NHS board must prioritise the requirements to meet national standards.

An improvement action has been developed by the NHS board and is available on both the Healthcare Improvement Scotland website: healthcareimprovementscotland.scot and the Mental Welfare Commission website: mwcscot.org.uk

We are grateful to all those who took the time to engage with us as part of this joint visit/investigation process undertaken by the Commission and Healthcare Improvement Scotland.

Appendix A:

The role of the Mental Welfare Commission and Healthcare Improvement Scotland

The Commission is an independent organisation originally established by the Mental Health (Scotland) Act 1960. It is uniquely placed to safeguard the rights and welfare of individuals with a learning disability, mental illness, dementia or related condition.

The Commission is also a corporate parent under the Children and Young People (Scotland) Act 2014, with duties conferred to promote and protect the welfare of care experienced children and young people. The rights of the child were further expanded through the United Nations Convention on the Rights of the Child (Incorporation)(Scotland) Act 2024 and therefore, as a listed authority, the Commission is also duty bound to act and report in compliance with this legislation and incorporated UNCRC articles.

Mental Welfare Commission

Our focus is on individuals and their experience of care and treatment. We make sure that the care and treatment of a person with a mental health condition (children, young people and adults) is in line with the principles of both the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA 2003) and the Adults with Incapacity (Scotland) Act 2000 (AWIA 2000).

Section 13 of the MHA 2003 describes the visits that the Commission is authorised to undertake. Our engagement and participation officers, mental health nurses, social workers (mental health officers) and psychiatrists visit and speak to people who use services, their carers, their families, their advocacy supporters and their mental health officers so that we can understand what their experience of care is like. We aim to identify both good experiences but also areas of care, treatment and law which are not respecting the rights of the person being cared for. We also speak with staff and managers to understand what they are doing to provide the highest quality care, treatment and support according to mental health and incapacity legislation.

Healthcare Improvement Scotland

The role of Healthcare Improvement Scotland is to support, ensure and monitor the quality of healthcare in Scotland by providing objective and independent quality assurance of healthcare services provided in Scotland

The organisations core purpose is to enable the people of Scotland to experience the best quality health and social care, with a specific focus on safety. It is part of Healthcare Improvement Scotland's Safe Delivery of Care Inspection Methodology to review systems, culture, leadership and governance of areas inspected.

The statutory duties for Healthcare Improvement Scotland are set out in the [Public Services Reform Act \(Scotland\) 2010](#) and the [National Health Service \(Scotland\) Act 1978](#).

Healthcare Improvement Scotland has adapted the safe delivery of care inspection methodology to minimise the impact of inspections on both the young people receiving care and the staff delivering that care. Our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We will keep discussion with clinical staff to a minimum and

reduce the time spent looking at care records.

Further information about the methodology for safe delivery of care inspections can be found on our website. [Child and Adolescent Mental Health Inpatient Services inspection programme – Healthcare Improvement Scotland](#).

Appendix B – List of References

The following references to national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

¹ [NHS Scotland CAMHS Model \(2\).pdf](#)

² [Carers, consent, and confidentiality](#)

³ <https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/pages/3>

⁴ [6. Principles and Standards for Independent Advocacy Reflecting Commissioners' Statutory Responsibility - Independent advocacy: guide for commissioners - gov.scot](#)

⁵ [SocialCircumstancesReports GoodPracticeGuide 2022 1.pdf](#)

⁶ <https://www.nice.org.uk/guidance/ng10>

⁷ [Rights, risks and limits to freedom](#)

⁸ <https://www.nsc.org/getmedia/a291988d-7fc6-4fbc-98f3-76ac5f7f0570/patient-restraints-english.pdf.aspx>

⁹ [Naso-Gastric-Tube-feeding-under-restraint.pdf](#)

¹⁰ [MedicalTreatmentUnderPart16MHA 2021 0.pdf](#)

¹¹ [Specified persons good practice guide](#)

Appendix C - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

1. [Allied Health Professions \(AHP\) Standards](#) (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, January 2016)
2. [Covert Medication](#) (Mental Welfare Commission, May 2022)
3. [Food Fluid and Nutritional Care Standards \(Healthcare Improvement Scotland, November 2014\)](#)
4. [Generic Medical Record Keeping Standards \(Royal College of Physicians, November 2009\)](#)
5. [GIRFEC principles and values - Getting it right for every child \(GIRFEC\)](#)
6. [Health and Care \(Staffing\) \(Scotland\) Act \(Scottish Government, 2019\)](#)
7. [Health and Social Care Standards \(Scottish Government, June 2017\)](#)
8. [Infection Prevention and Control Standards \(Healthcare Improvement Scotland, 2022\)](#)
9. [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003 \(Scottish Government, 2003\)](#)
10. [Mental Health Scotland Act 2015 \(Scottish Government, 2015\)](#)
11. [National Infection Prevention and Control Manual \(NHS National Services Scotland, June 2023\)](#)
12. [National child protection guidance – Child Protection](#) (Scottish Government, 2023)
13. [NMC Record keeping: Guidance for nurses and midwives](#) (Nursing & Midwifery Council, August 2012)
14. [Operating Framework: Healthcare Improvement Scotland and Scottish Government](#) (Healthcare Improvement Scotland, November 2022)
15. [Person Centred Care Plans](#) (Mental Welfare Commission, August 2019)
16. [Person-centred care](#) (Nursing & Midwifery Council, December 2020)
17. [Preparation of care plans for people subject to compulsory care and treatment](#) (Mental Welfare Commission, October 2021)

18. [Prevention and Management of Pressure Ulcers - Standards](#) (Healthcare Improvement Scotland, October 2020)
19. [Professional Guidance on the Administration of Medicines in Healthcare Settings](#) (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
20. [Rights, risks, and limits to freedom](#) (Mental Welfare Commission, March 2021)
21. [Scottish Patient Safety Programme SPSP](#) (Healthcare Improvement Scotland)
22. [The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives](#) (Nursing & Midwifery Council, October 2018)
23. The Quality Assurance System (Healthcare Improvement Scotland, September 2022)
24. [The UNCRC Act - UNCRC \(Incorporation\) \(Scotland\) Act 2024](#) (Scottish Government, February 2024)