



**mental welfare**  
commission for scotland

**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Flats 1, 2 and 3, Strathmartine  
Centre, Dundee DD3 0PG

**Date of visit:** 13 August 2019

## **Where we visited**

Flats 1, 2 and 3 are in-patient units at the Strathmartine Centre which is just outside Dundee. Flat 1 is a low-secure environment for male patients with learning disabilities and offending behaviour and has eight beds. Flat 2/3 is a behavioural support and intervention unit with nine beds, providing care and treatment to adults with learning disability who can display stressed/distressed behaviours.

We last visited this service on 16 October 2018 when we made recommendations about nurse staffing and about filing Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') documentation. We received a response which told us about actions being taken to address these recommendations.

NHS Tayside is in the process of redesigning mental health and learning disability inpatient services and the new service model will see learning disability inpatient services provided from wards at Murray Royal Hospital in Perth. On the visit in October 2018 we were told that there was no set timescale for wards at Strathmartine Centre to move to Murray Royal Hospital, but we understood that this was likely to happen later in 2019. We had therefore intended to visit wards currently based at Strathmartine Hospital after the transfer to Murray Royal Hospital. However, the Commission heard in July that the Craigowl Unit, one of the wards at the Strathmartine Centre, had just been closed and that the patients in that ward had been moved to the other units on the site. We had also heard that the planned move to Murray Royal Hospital would not be taking place in the immediate future. We decided therefore to revisit the in-patients units at the Strathmartine Centre now, under a year since our previous visit, to look generally at the provision of care and treatment in the wards following on from the ward closure and the moves patients had experienced on site.

## **Who we met with**

We met with and/or reviewed the care and treatment of ten patients. We also spoke with the charge nurses in the wards and with the service manager.

## **Commission visitors**

Ian Cairns, Social Work Officer

Douglas Seath, Nursing Officer

Paula John, Social Work Officer

## **What people told us and what we found**

We met a number of patients during this visit and they were positive about the care and support they were receiving on a day to day basis from nurses in the wards. Several patients told us about how they felt involved in decisions about their care and treatment and described a range of activities that they were able to engage in within the Strathmartine Centre and in the community. Patients also gave feedback about how they felt staff responded well if issues were raised with them and the positive interactions between staff and patients we observed during the visit reinforced the feedback we had from patients about how supportive they felt staff were.

While patients did provide positive feedback to Commission visitors, we also heard a number of comments from patients who were unhappy about recent changes on-site, and about the effect having been moved to a different ward has had for them. We heard that some patients were no longer able to do specific simple daily living tasks independently, such as make cups of hot drinks when they wanted to, or serve themselves at breakfast time. We heard other examples of patients feeling that the move to a different ward had been a backward step for them because more restrictions were in place and one patient described how they were isolating themselves by spending more time in their bedroom because they were struggling in a new environment having to mix with different patients. Patients also told us that they were only informed they were moving into a different unit on-site on the day that this happened, very shortly before they had to move and they were unhappy that there had been no discussion about this beforehand. We also heard from staff that several patients have been distressed by the moves and have been displaying more stressed/distressed behaviours.

### **Recommendation 1:**

Managers should review the impact of the ward changes and the patient moves on each individual patient. Where it is identified that patients are experiencing unnecessary restrictions as a consequence of moves then managers should take steps to minimise the impact of any restrictions of an individual patient by patient basis.

## **Care Planning**

Nursing care plans are important tools which identify the detailed plan of nursing care and specific interventions necessary to meet individual needs. On this visit we reviewed 10 individual patient files and looked at the care planning information in these files.

Care plans overall were reasonable and we saw some specific plans which were meticulous and person-centred and which had information about interventions which were well-described. We also saw that appropriate risk assessment and risk management plans were in place in files. We did see that different formats were being used for care planning and in some files we noted that care planning information was all included within risk management tools. In some files care planning information was set out in a care programme approach format (Care Programme Approach or CPA, is a framework which can be used to assess needs and improve the co-ordination of care). We also noted that care plans were variable and that not only were different formats being used but some individual care plans were less detailed.

The Commission expects to see that care plans are reviewed and evaluated regularly. In some of the files we reviewed we saw clear evidence that this is happening, with dates clearly recorded when further reviews were to take place. Some files though had limited evidence of regular reviews of care plans or of the effectiveness of interventions being evaluated. There will be occasions when plans may have been reviewed and the outcome has been that no changes need to be made to plans but in some files this has not been recorded if this was what had happened.

With regard to care planning people should be encouraged to be involved as much as they can be in decisions about their care and treatment. In some of the files we saw that care plans were signed by individual patients and one patient showed us a folder they kept in their room which had copies of their care plans. We also saw easy read versions of some documents in files, but if patients have difficulties understanding written information then having copies of a written care plan would be of limited value to them and we did not see any easy read versions of care plans in files. We feel that the service should look therefore at how participation of patients can be promoted, including the use of easy read versions of documents.

We discussed issues about care planning on the visit with charge nurses and the service manager. We heard about work which is ongoing within NHS Tayside, developing a person centred approach across mental health learning disability services. We know that NHS Tayside has published standards for person centred care planning earlier this year and this is referenced in new Mental Welfare Commission undertaken by a care planning collaborative in Tayside, which involves staff from learning disability services. Link:

[https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans\\_GoodPracticeGuide\\_August2019\\_0.pdf](https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf)

The Commission also understands different care planning formats may be appropriate for patients with different needs and that the CPA format for example is more appropriate for individual patients with very complex needs. We would encourage the service to continue to progress the work focussing on person centred care planning so that there is a consistent approach to this issue across in-patient services.

### **Recommendation 2:**

Managers should ensure that there are regular audits of care plans, to ensure consistency in recording and reviewing.

### **Multi-disciplinary input within the wards**

The Commission was aware before this visit that there have been significant issues about medical input in the service and that for a period there was no learning disability psychiatry cover. Every patient who is detained in hospital should have a responsible medical officer (RMO) who is responsible for their care and treatment and generally the RMO will be a consultant psychiatrist. Before this visit we had been told that psychiatrists from the forensic service in Tayside would be taking RMO responsibility for patients on specific orders but we wanted to find out on this visit about the medical input to the multi-disciplinary team (MDT) in the wards. We were told that it had not been possible to arrange for learning disability consultant psychiatry cover for a period of time but we were assured that the situation has now been resolved. We did hear there are still vacancies in the clinical psychology service and

that this could have an impact on patients because certain therapeutic supports may not be available. Where vacancies are having an impact on the care and treatment being provided within the units, the Commission would expect NHS Tayside to fill vacancies as soon as possible.

With regard to MDT input within the wards we did look at the records of MDT meetings within individual patient files. We found that records of MDT meetings were often very brief, so that while there was evidence of MDT meetings taking place, it was often not clear that these meetings were reviewing the provision of care and treatment in great depth. We would encourage the service to look at how MDT meetings are being recorded, so that the notes of meetings reflect who participated in the meetings and what meaningful discussions or decisions had taken place.

### **Use of Mental Health Act and Incapacity Legislation**

We looked at the consent to treatment documentation (T2 and T3 forms) under the Mental Health Act which authorise treatment when a patient is compulsorily detained in hospital. In one case we noted that a T3 form had been completed very recently but that this should have been in place some time before. Another patient had a T2 form, the form which is completed when a patient is able to consent to treatment prescribed and is agreeing to take this treatment. This form only covered some of the medication which was prescribed though, which meant that some of the medication prescribed was not properly authorised. We have written to the RMO about this and as we have said above we were told that there had been issues in the service about having no regular medical input from a consultant psychiatrist. It is important that all medication prescribed when patients are in hospital is properly authorised.

#### **Recommendation 3:**

Managers should ensure that medication prescribed is reviewed by RMOs and the pharmacy service and that all medication is appropriately authorised.

In one file we look at we saw that the SUS form, the certificate which authorises periods of time when a patient detained in hospital can be allowed out of the hospital, had been mislaid and was not in the file. This had resulted in the individual patient having restrictions in place which were unnecessary. We also saw that a RES form was not in place for one patient, to authorise restrictions on phone use. Sections 281-286 of the Mental Health Act provide a framework which restrictions can be placed on people who are detained in hospital but RES forms are the appropriate forms which should be in place when a patient has been made a specific person under these sections of the Mental Health Act. Both these issues have been followed up by the Commission.

#### **Recommendation 4:**

Managers should ensure that all documentation, as required by the Mental Health Act, is completed when appropriate, so that restrictions are legally authorised. Managers should also ensure that copies of forms are filed appropriately.

## **Rights and restrictions**

Patients in units have good access to independent advocacy support and we saw that one of the independent advocates was in the unit on the day of our visit. Several patients we met also told us about the support they get from independent advocacy and said that their advocate comes to meetings to review their care and treatment if they want this support.

As mentioned earlier in this report we did hear from staff and patients that the closure of one ward on site and the consequent move of patients into other wards has had an impact on some patients. Some patients clearly do feel that they are experiencing more restrictions in relation to things they can do independently and comments we heard from staff echo these views that some patients have been distressed by the moves. We have made a recommendation earlier in this report in relation to this issue.

## **Activity and occupation**

There is a broad range of activity provision within the units and in the day service in the grounds at Strathmartine Centre. There seems to be a good emphasis on activities to develop daily living skills and individual patients spoke positively about activities they engage in, including activities in the community in Dundee.

## **The physical environment**

Because of the ward closure and the consequent move of some patients within the service, some areas within the units do feel cramped, with limited space. We heard that one office has been made into a bedroom to accommodate patient moves and we saw how a partition has been put up in one unit and that there was now a lack of quiet areas for patients. Plans are still being taken forward to move current inpatient provision from the Strathmartine Centre to the Murray Royal Hospital but there is still no firm timescale for this move to take place. Until the service moves to Murray Royal Hospital managers must make sure that care and treatment is being provided in an appropriate environment in the current wards at Strathmartine Centres.

## **Any other comments**

The process of taking forward plans for the redesign of learning disability in-patient services has been prolonged and there is still no firm timescale for any moves. NHS Tayside has also been experiencing great difficulty filling learning disability nursing posts within the in-patient service at Strathmartine Centre.

We spoke to staff on the day of our visit and staff did seem to be positive about the work they are doing in the service on a day to day basis. It was clear though that staff morale is low because of uncertainty about when planned changes may take place and because of the significant issues there have been with staff shortages and posts not being able to be filled. We feel it is important that NHS Tayside has a clear strategy for communicating with staff and for listening to and addressing issues they want to raise.

## **Summary of recommendations**

1. Managers should review the impact of the ward changes and the patient moves on each individual patient. Where it is identified that patients are experiencing unnecessary restrictions as a consequence of moves then managers should take steps to minimise the impact of any restrictions of an individual patient by patient basis.
2. Managers should ensure that there are regular audits of care plans, to ensure consistency in recording and reviewing.
3. Managers should ensure that medication prescribed is reviewed by RMOs and the pharmacy service and that all medication is appropriately authorised.
4. Managers should ensure that all documentation, as required by the Mental Health Act, is completed when appropriate, so that restrictions are legally authorised. Managers should also ensure that copies of forms are filed appropriately.

## **Service response to recommendations**

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

ALISON THOMSON  
Executive Director (Nursing)

## **About the Mental Welfare Commission and our local visits**

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons Inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.



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