Mental Welfare Commission for Scotland

Report on announced visit to: The Mulberry Ward, Carseview Centre, 4 Tom McDonald Avenue, Dundee, DD2 1NH

Date of visit: 6 April 2021

Where we visited (virtually)

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's Routemap (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits, however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out face-to-face.

Mulberry Ward is a general adult psychiatric acute admission ward in the Carseview Centre. It is a mixed-sex ward, with 20 beds which are all in single rooms. It provides admission beds for the Angus area in NHS Tayside, and on the day of our visit the ward was full.

We last visited this service on 22 January 2020. This was a visit to all three general adult admission wards in the Carseview Centre, and recommendations were made about care planning, about auditing authorisation of treatment, about the locked door policy in each ward, and about maintaining the confidentiality of information in the duty rooms in the wards.

Unfortunately this report did not go out to the service immediately after it was completed, as the process for finalising and publishing reports was interrupted by the Covid-19 lockdown which came into effect in March 2020. The Commission therefore did not receive a response to the recommendations from the previous visit, and on this visit we wanted to look generally at care and treatment in Mulberry Ward, taking account of what we had seen on the visit in January 2020.

Who we met with

We met with and/or reviewed the care and treatment of 10 patients on the day of the visit, and spoke to one relative on the phone.

We also spoke with the senior charge nurse (SCN), and other members of the nursing team, and with one consultant psychiatrist who was on the ward and undertaking patient reviews on the day of the visit. We also met the lead nurse for mental health and learning disability inpatient services.

Commission visitors

Ian Cairns, Social Work Officer

Alyson Paterson, Social Work Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Comments from patients

Patients we spoke to on the day told us they had good relationships with nursing staff and generally were positive about the day-to-day care that they were receiving. Some specific individual issues were raised, such as the availability of psychological therapies and access to the garden area; these will be discussed later in this report.

However, we consistently heard comments about how staff were available when patients felt they needed to speak to someone and that staff make time for them even when they are clearly busy and stretched, and spend time with them. Patients were clear that they had a named nurse, and most could confirm that they had a care plan, with several people telling us that they knew what was in their plan, and that they had been involved in preparing and discussing their care plan. This included comments from several patients who had recently been admitted to the ward, and spoke about how their named nurse had spent time talking with them about their care plan.

When patients spoke to us about the multidisciplinary team (MDT) meetings which are held in the ward, they said they were able to participate in these meetings and that they felt that their views were heard. While speaking to a group of patients in the lounge, the occupational therapist (OT) in the ward came in and one patient went with them for a planned activity session. This prompted several positive comments from the other patients about the activities they were able to engage in with the OT.

The one relative we spoke to during the visit was also positive about the support provided by staff. They recognised that their daughter had complex care needs which would be better met in a more specialist inpatient unit, but they said specifically that staff are excellent, that '"they go beyond the call of duty'" and that they always keep the family in the loop in discussing the care and treatment being provided.

Care planning and treatment and support

On several previous visits to the general adult wards at Carseview, the Commission made recommendations about care planning and about the need to ensure more consistency in the approach to care planning. NHS Tayside has produced a set of standards, 'Mental health nursing: standards for person centred care planning', and we were told that these standards are being implemented on an ongoing basis, with care plans being audited regularly.

On this visit we reviewed care plans for just over half the patients in the ward. We found that care plans were clear, and that most of the care plans we reviewed were detailed and person centred, with information about relevant goals and interventions. We did note that some plans could have had more specific information about actual interventions being provided by nursing staff, and as an example we saw several plans which referred to patients identifying distraction techniques, or using distraction techniques which they had previously found helpful, but without the specific distraction techniques which helped that individual patient

being detailed in the care plan. The Commission would expect that kind of specific information to be recorded in a care plan, so that all staff in the ward can easily see how a patient can be best supported. We did see evidence of regular reviews in care plans, generally on a weekly basis, with comments about any specific actions from a review clearly recorded, with care plans updated regularly in the electronic record.

Most care plans referred to patients having regular one-to-one time with nurses, and as mentioned above we did hear comments from several patients about how this is happening. We saw information in daily progress notes about one-to-one sessions with patients, but these could be better recorded in the progress notes, and the recordings could be more goal focussed. We also saw that patient participation in care planning could also be better recorded. The need for this is specifically identified in the mental health nursing standards which NHS Tayside has produced and as these standards become embedded in the practice in the wards, the Commission would expect to see an emphasis on recording how patients were involved in care planning and one-to-one discussions.

We would also want to see a record of the reasons when a patient does not want to be involved or is unable to be involved in care planning. As care plans are now being audited regularly by managers, the Commission would encourage a focus on how the electronic record demonstrates the involvement of the person.

In the files we reviewed we saw compressive risk assessments specific to the individual patient, and we saw that these are being reviewed. We also saw the records of MDT meetings, taking place weekly, and we felt these were reasonably well recorded, with information about who attended these meetings.

The consultant psychiatrist we met during the visit described the format that is being used to try to help the patients engage in these MDT meetings, with a My Care/My Treatment document being used so that patients can fill these in in advance, to make sure that issues they want to raise at MDT meetings are discussed. We also heard from the consultant how patients will be asked about whether they want to attend meetings, and that if a patient finds a large meeting intimidating, then staff input into the meeting will be restricted to the minimum appropriate number. We did hear that completing the My Care/My Treatment form in advance of MDT meetings had not been happening consistently for a period of four or five weeks, because staff shortages in the ward had led to a lack of staff availability to support patients to complete the forms in advance. We were pleased to hear that this has since been addressed, and we would want to see the service using this My Care/My Treatment approach regularly, to make sure that patients are participating as much as possible in their MDT review meeting.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Multidisciplinary input in the ward

We heard that there is now good input from junior doctors and doctors in training posts into the ward, and although the occupational therapist is not dedicated solely to Mulberry Ward, and works across all the adult admission wards, we heard from patients that they valued the OT input. Several patients mentioned that the lack of physiotherapy input into the ward is limiting activity provision, and access to gym equipment which is on site. This was discussed with managers on the day, and we were told that the physiotherapy post has been filled, and that a worker was due to be starting within a few weeks.

The main deficit in the ward is the lack of availability of clinical psychology. Two patients told us they were unhappy with this and felt let down by the lack of psychological therapy support in the ward. One of these patients said that the lack of specialist psychology input will mean they will be transferred to another unit a considerable distance away. From file reviews we could see that there were a number of patients who could clearly benefit from input with the clinical psychology service.

Several patients who have recently been diagnosed with autistic spectrum disorder now have contact with a psychologist from the specialist autism service. However, there are other patients who are not able to access clinical psychologist support, and it was also clear on the visit that staff feel that input such as this would be helpful, particularly with regard to the process of psychological formulation, an approach describing an individual patient's needs, precipitating factors which may be contributing to needs, and interventions to meet needs.

The issue about the availability of psychological therapies in the ward was discussed with the SCN and lead nurse at the end of the visit, and the Commission was advised that a proposal for developing dedicated psychology input into the service was being prepared. We also heard that it was hoped that in future nursing staff in the ward will receive training and support, to deliver specific psychological therapies such as decider skills, an approach which is designed to help patients recognise their own thoughts, feelings and behaviours, and to manage their own emotions and mental health.

Recommendation 1:

Managers should progress the plans to have dedicated clinical psychology input into the ward, and to develop a range of psychological therapies which can be delivered by nursing staff in the ward.

During the visit we saw that there are a considerable number of patients in Mulberry Ward who have very complex needs, and we heard that this has been recognised by management with additional staffing being allocated to the ward. We also heard how a number of patients have a diagnosis of emotionally unstable personality disorder, and psychological therapy is considered to be a first line treatment for people with such a diagnosis. We feel that the current patient mix within Mulberry Ward supports the argument for having dedicated psychology input into the ward.

During the visit we noted that a number of patients were ready to be discharged, but could not be discharged until either accommodation was identified, or issues about accommodation

they had already been allocated had been addressed. It is important that these issues are identified and addressed as soon as possible during an admission to hospital. We would expect care managers and/or mental health officers to be looking at accommodation needs at an early stage. We did speak about discharge planning during the visit, and were told that the lack of a fully functioning crisis resolution and home treatment team (CRHTT) in Angus has an impact on discharge planning, and leads to some patients remaining in the ward for longer than is necessary. If the CRHTT service in Angus was fully operational, these patients could be discharged promptly with the relevant support.

This issue has been highlighted in several recent reports. The Healthcare Improvement Scotland (HIS) report, review of adult community mental health services Tayside, which was published July 2020 spoke about the inequity of service provision across the three partnership areas in Tayside, and particularly about the inequality and the provision of crisis home visit services.(http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/tayside_mental_health_jul_20.aspx).

This report said that Angus lacked a seven day home treatment team, and that this issue had first been highlighted in the HIS report in December 2017. The recent Strang report, 'Trust and Respect: a final report of the independent enquiry into mental health services in Tayside', also spoke about a seven day CRHTT in Angus being unavailable for five years, and that there was no doubt that during this time "there has been detriment to patients discharged from Carseview Centre to the Angus community who did not receive adequate intensive home treatment or supported discharge". (https://independentinquiry.org/final-report-of-the-independent-inquiry-into-mental-health-services-in-tayside/)

The Strang review also highlighted that the plan had been to expand community mental health services in Angus to a seven day service starting from January 2020, but that this has still not happened. There is an inequity in service provision as a seven day community service is not available in Angus unlike in other parts of Tayside, and it would seem likely that this could prevent earlier discharges from Mulberry Ward to the community in Angus.

Recommendation 2:

Managers should ensure that there is a clear timescale for the establishment of a seven day home treatment team service in Angus.

We heard from staff during the visit that there has been a very significant increase in patient acuity over the past year, because of the number of patients with very complex needs requiring increased nursing support. We also heard how more patients with a diagnosis of emotionally unstable personality disorder have been admitted to the ward in this period. We were pleased to hear from the consultant psychologist about work being done to support patients with this specific diagnosis. An increase in the availability of psychological therapies will benefit patients with this diagnosis, but in the meantime other approaches are being introduced to try to support patients to develop coping skills.

Use of mental health and incapacity legislation

On the day of our visit ,half of the patients in Mulberry Ward were subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 '(the Mental Health Act') paperwork relating to the Mental Health Act was filed appropriately, in a separate folder for each patient, and was easy to access.

We reviewed forms for consent to treatment under the Mental Health Act (T2 and T3 forms). We found two issues which needed to be addressed on this visit. In one case a T3 form, the form authorising medical treatment where an individual is not able to or not giving consent, was not filed with the patient prescription chart. We checked retrospectively and in this case the Commission had received a copy of the relevant T3 form, so that authorisation was in place. However the Commission's advice is that a copy of this form should be filed with the individual patient prescription chart, as this enables nurses administering prescribed medication to check that the medication is properly authorised. In another case we noted that the T2 form had been completed authorising a particular medication to be administered either orally or by injection. The Commission's view is that it is best practice for medication which can be administered via different routes to be listed separately on a T2 form. Both these issues were highlighted to managers at the end of the visit.

Rights and restrictions

The door to Mulberry Ward was locked on the day of this visit. We were told that the door has often been locked over the past year, because the level of acuity in the ward has been very high, and there has often been a specific clinical need to keep the door locked in the ward. We did note that there is a notice at the entrance to the ward informing visitors about the locked door.

During the visit we spoke to a number of patients together in a group in the lounge, who were all informal patients. They all knew that they were informal patients, and that they could ask to go out of the ward when the door was locked. Several patients did say though that while they knew they were not detained in the ward they did feel that they would be likely to be detained if they insisted that they wanted to leave the ward.

We were aware that several informal patients could go out of the ward unescorted when they asked to, and one patient said that their experience was that they felt able to get out of the ward when they wanted to. Some informal patients had restricted time out of the ward, and we heard several comments from patients who agreed that they did feel they should have a nurse with them when they left the ward, because this helped them to feel safer. We feel it is important though that staff in the ward are aware that if a restriction is in place limiting the opportunity for an informal patient to leave the ward then this can amount to de facto detention, which is when a patient is not detained in hospital but their perception is that they are not allowed to leave or that if they try to leave they will automatically be detained.

We did speak to the consultant about this issue during the visit, and we were told that there is a clear process in place in such situations, and that ward staff would arrange for an urgent medical assessment if they are concerned when someone is wanting to leave the ward, and

that this assessment would focus on whether the criteria for detention were met and whether detention was appropriate. The Commission recognises the importance for all staff in the ward to be aware of this process.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

Activity provision has been more limited during the Covid-19 pandemic, with opportunities for patients to engage with community resources being suspended for considerable periods of time.

Patients and staff commented positively on the OT input into the ward, but everyone who commented on this said there should be more dedicated input as the OT works across all three admission wards. Ward staff do try to engage patients in activities as well, and there is a noticeboard prominently displayed in the corridor which has information about planned activities. However, we noted that it is difficult for staff to provide activities consistently, because other clinical tasks in the ward have to take priority.

We heard during the visit that there has been a pilot project with a dedicated activity worker in one of the other admission wards, and it is now planned to extend this provision and to have a dedicated activity worker in each ward. One patient told us that they knew about this activity worker in a different ward, and that they also hoped that an activity worker post would be established in Mulberry Ward.

As noted earlier, we were aware of lack of access to gym facilities in the Carseview Centre, created by a vacant physiotherapist post, where previously completed assessments by the physiotherapist would have enabled patients to use gym equipment. With a new physiotherapist starting in the near future, we heard that the plan is for the physiotherapist to train nursing staff in the ward to enable them to undertake the appropriate gym equipment assessments with patients, so that patients would be able to access the gym area much more readily, even when the physiotherapist is not working.

A significant number of patients told us during the visit that they felt frustrated not being able to access the garden area in Carseview. One patient told us that they were able to go of the ward by themselves and had found an attractive nature walk in the hospital grounds. Most patients who commented about this told us though that they simply wanted to be able to go and use the sheltered garden area which is part of the Carseview Centre.

The other two admission wards in Carseview have immediate access into the garden space, because these wards are both on the ground level. Mulberry Ward is one floor above the garden area, and patients who want to go out into the garden have to be escorted by nursing staff downstairs through a fire exit from the ward. This significantly limits the access which most patients have to relax and socialise in an outside space, and we heard that staff feel equally frustrated by this arrangement. While Mulberry Ward remains as an admission ward

on the first floor level it is difficult to see how access to the garden space can be significantly improved. It is a significant issue though for patients in the ward, that they can see a well laid out and sheltered garden space from the ward, which is not readily accessible.

Recommendation 3:

Managers should review how access to the garden space can be improved for patients in Mulberry Ward.

The physical environment

On the visit we heard there has been a significant refurbishment program in Mulberry Ward, with much of the environment being repainted and significant improvements in the bathroom areas in the en-suite rooms.

When we visited the wards in the Carseview Centre in January 2020 we heard about the plans for major refurbishment work in the wards, with a new room specification having been agreed with input from staff and patients, and with one room in an unused part of the building having been refurbished using the new room specification standards. We heard then that the plan was for all the rooms in the wards to be refurbished to this standard, but this plan has not been progressed, and although refurbishment work has been completed in Mulberry Ward we understand that other environmental improvement work is still planned.

Recommendation 4:

Managers should provide the Mental Welfare Commission with information about when rooms in Mulberry Ward will be refurbished to the new room specification standards.

Summary of recommendations

1. Managers should progress the plans to have dedicated clinical psychology input into the ward, and to develop a range of psychological therapies which can be delivered by nursing staff in the ward.

2. Managers should ensure that there is a clear timescale for the establishment of a seven day home treatment team service in Angus.

3. Managers should review how access to the garden space can be improved for patients in Mulberry Ward.

4. Managers should provide the Mental Welfare Commission with information about when rooms in Mulberry Ward will be refurbished to the new room specification standards.

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.

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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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