Mental Welfare Commission for Scotland

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

Date of visit: 23 November 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (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 a variety of face-to- face and/or virtual visits. This local visit was able to be carried out face-to-face.

We visited Ward 1, which is a 22-bedded mixed-sex general adult admission ward based in the Carseview Centre. It offers admission for those in the Dundee West area in NHS Tayside; on the day of our visit the ward was full. There are four beds allocated to the Advanced Intervention Service (AIS), a national specialist service providing assessment and treatment for patients across Scotland who have attracted a diagnosis of severe treatment refractory depression and obsessive compulsive disorder.

We last visited Ward 1 on 22 January 2020 and discussed a number of areas that required attention including care planning, auditing of forms for the authorisation of treatment, the locked door policy, and maintaining the confidentiality of information in the main office area in the ward.

Unfortunately, due to the pandemic, the previous recommendations and service response were delayed, however on this visit we wanted to review the care and treatment in the ward, taking account of our findings from our visit in January 2020.

Who we met with

We met with and/or reviewed the care and treatment of five patients during this visit. We spoke with the Senior Service Manager, Lead Nurse, Senior Nurse, Senior Charge Nurse, and a Consultant Psychiatrist.

Commission visitors

Alyson Paterson, Social Work Officer

Anne Buchanan, Nursing Officer

What people told us and what we found

Care planning, treatment, support and participation

Comments from patients

All of the patients we met with during our visit spoke highly of the staff in the ward and they spoke positively of the care, treatment and support they had been receiving. We heard that staff treated patients with dignity and respect, were approachable, and made time when patients needed to speak to someone. Patients talked of having regular one-to-one sessions with nurses, as well as praising the student nurses that were on placement in the ward. However, patients told us they were aware there are nursing staff shortages and felt their care would benefit from having more staff available to them. During our visit we witnessed staff spending time with patients, either talking with them or engaging in activities such as board games.

Patients we spoke to were mainly positive about the ward environment, describing feeling safe there. Some patients were positive about the outside courtyard space and the opportunity to smoke which they saw as beneficial and calming. Others told us the smell of smoke in the sitting room next to the garden stopped them from socialising with their peers.

Patients told us they felt the clinical team, including medical staff, offered them opportunities to discuss their concerns and that they felt included in their care and treatment. We also heard that patients found the chaplain as helpful and someone they liked to talk to. However some patients we spoke to told us that it would have been beneficial to have a psychologist on the ward to help with conditions such as post-traumatic stress disorder.

Patients were aware that they had a named nurse, most were aware that they had a care plan and either had a copy or knew they could have a copy if they so wished. The patients we spoke to felt involved in their care plan and that their views were taken into account.

Care planning and treatment and support

During previous visits to general adult mental health 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 planning', and we were told that these standards are being implemented on an ongoing basis, with care plans being audited regularly.

During this visit, we were pleased to find that care plans were clear, detailed and showed evidence of review. They were goal and recovery focused with clear interventions and there was evidence of discharge planning. A patient-centred model to care planning was clearly evident, as was patient participation in the care plans. However, when a patient chooses not to be involved or is unable to be involved in care planning we would want to see this recorded. Care plans are held electronically and can also be printed out. We saw some paper care plans which were signed by the patient but some were not. We would like to see a record of the

reason why a care plan is left unsigned and evidence of attempts to engage a patient in participating in their care plan.

In the files we reviewed we saw comprehensive risk assessments which were person-centred and showed evidence of review. The files showed evidence of multidisciplinary team (MDT) meetings and evidence of one-to-one input from nursing staff. Evidence of a psychological approach to care and treatment with interventions, for example mindfulness, to reduce distress, were found in the documentation we reviewed.

To support ongoing quality of care plans and documentation, there are regular audits undertaken by the nursing team. This is a peer-led model and we found that this process has led to an improvement in the quality of the care pans. Patients are encouraged to provide feedback and staff informed us that this has definitely led to a collaborative approach between patients and their keyworker.

During our visit we were impressed with the quality of the information held in patient files. We were informed that there is an active programme for improvement work and we could see evidence of this in the records we reviewed.

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/node/1203

Multidisciplinary input in the ward

We heard that there is input into the ward from a range of different disciplines. There are three dedicated consultant psychiatrists for the ward; however one is a locum who is due to leave their post. Additionally, there is a pharmacist who attends MDT meetings. The ward has access to a full-time physiotherapist and there is a gym on the ward where sessions with the physiotherapist can take place. We heard positive feedback from those patients who chose to use this facility. We were pleased to hear that funding has been approved for the purchase of electric bikes and that there are plans in place to begin seated exercise sessions.

Occupational therapy (OT) staff run a number of different groups on the ward including relaxation and cooking groups. OT is highly valued by patients and the nursing team, although unfortunately there has been less input during the last 12 months partly due to Covid-19. We were pleased to hear funding has been made available for a full-time activities co-ordinator and that until this post is recruited in to, activities will continue to be provided by nursing staff and the OT.

The main deficit on the ward is the lack of availability of clinical psychology. We were told by patients and the clinical team that having psychology input into the ward would be hugely beneficial. The team recognise providing a model of care that offers psychological therapies along with psychological formulations would enhance nursing knowledge and support patients who have attracted a diagnosis of personality disorder.

During our visit we saw there were a number of patients in the ward who have complex needs including some with a diagnosis of emotionally unstable personality disorder. Psychological therapy is considered to be a first line treatment for people with such a diagnosis and as such we feel this supports the need to have dedicated psychology input into Ward 1.

Recommendation 1:

Managers should ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and patient groups.

Recommendation 2:

Managers should ensure that vacant posts are recruited to, and that a dedicated activities support worker has input into, the ward.

During our visit, we were made aware of a number of patients who were ready for discharge however this was delayed due to accommodation issues or because they required specialist packages of support. It is important that these issues are identified and addressed as early as possible during an admission to hospital. We would expect social work care managers/mental health officers (MHOs) to be identifying these needs and be planning for discharge at an early stage to prevent individuals being delayed in hospital unnecessarily.

During our visit, we were advised that the ward has good working relationships with social work care managers/MHOs. However, there is a significant waiting list for patients to be allocated a social worker. Additionally, the referral process to social work requires an e-mail to be sent to a social work team manager. Ward staff find it difficult to follow up referrals especially if the team manager is not available. We would like to see this process reviewed and a generic e-mail created for social work referrals. This would allow referrals to be actioned and followed up in a timely way.

Use of mental health and incapacity legislation

On the day of our visit, we reviewed a number of patients' files. Paperwork relating to the Mental Health (Care and Treatment) Scotland Act 2003 ('the Mental Health Act') was kept in a paper file and was accessible.

We reviewed forms for consent to treatment under the Mental Health Act (T2 and T3 forms). We found no issues or concerns in relation to these forms. During a previous visit, we found that that consent to treatment forms were not filed with prescriptions charts. We were pleased to see that these are now kept alongside medication prescriptions charts. We were advised by the charge nurse that consent to treatment forms are audited on a weekly basis.

When we were reviewing patient files we were looking for copies of advanced statements. The term 'advance statement' refers to written statements, made under s274 and s276 of the Mental Health Act, and is written when a person has capacity to make a decision on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements, however on the day of our visit, we were not able to locate any advanced statements. The Commission supports advance statements, as they are a way of ensuring

that people with mental ill health are listened to and have their human rights respected. We would like to see evidence of the attempts made to engage in a discussion regarding advanced statements and the reason noted for any patient that does not have one.

Rights and restrictions

On the day of our visit the door to the ward was locked. There is a locked door policy in place which is reviewed daily.

During our visit we spoke with a number of patients who were subject to Mental Health Act legislation and others who were in hospital informally. Of those patients we spoke to, all were aware of their rights and restrictions placed upon them.

We were told advocacy services are available for patients in Ward 1. Over the past year, these services have not been able to offer their usual drop-in service, this is due to Covid-19.

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

The physical environment

On the day of our visit, the ward was full. When patients are admitted and there is no bed immediately available for them, they are accommodated in a 'surge bed'. On the day of our visit, we discussed in detail the hospital policy of using 'surge beds'. A surge bed can be utilised for an emergency admission; we were told the bed should only be used for a period of 24 to 48 hours. Ward 1's surge bed is placed in a meeting room. It offers very little space, comfort or privacy. Apart from a single bed there are no other facilities for a patient's personal belongings. Access to bathroom facilities are via a corridor. We raised our concerns about this policy and the compromises to patient care, treatment and dignity. We have asked that the policy for the use of these beds in kept under review and that information regarding the frequency of use of surge beds be sent to the Commission.

Recommendation 3:

Managers should keep the policy for the use of surge beds under review and send the Commission information on their use.

While we were pleased to see the ward has direct access to a garden and seating area, we were concerned to see evidence of smoking and cigarette ends. This created the impression of an area that was not regularly maintained and appeared unkempt.

We were disappointed to see some curtains in communal areas and in patients' bedrooms needing to be re-hung or replaced as they did not fit the windows properly. We asked that these issues be rectified in the very near future.

Summary of recommendations

1. Managers should ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and patient groups.

2. Managers should ensure that vacant posts are recruited to, and that a dedicated activities support worker has input into, the ward.

3. Managers should keep the policy for the use of surge beds under review and send the Commission information on their use.

Good practice

While we were aware of the challenges for patients in relation to restricted visiting during the pandemic, we were equally aware of the impact that the Covid-19 pandemic has had on staff, specifically nursing staff. We were impressed to see and hear how staff have continued to provide a quality service despite the numerous challenges including staff shortages. We heard that as a result of the Strang Report, the ward has implemented changes such as the introduction of an improved observational practice floor nurse.

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.

Suzanne McGuinness
Executive Director (Social Work)

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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