mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Ward 2, Carseview Centre, 4 Tom Macdonald Avenue, Dundee DD2 1NH

Date of visit: 29 November 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

We visited Ward 2, which is a 22-bedded mixed sex general adult admission ward based in the Carseview Centre. It provides admission beds for the Dundee East area in NHS Tayside. We last visited this ward on 22 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 service manager, lead nurse, senior nurse, senior charge nurse (SCN) and a consultant psychiatrist.

Commission visitors

Alyson Paterson, Social Work Officer

Claire Lamza, Senior Manager

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 who 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 by engaging in one-to-one activities.

Patients we spoke to were mainly positive about the environment of the ward, describing feeling safe there. Some patients were positive about the outside courtyard space and the opportunity to smoke there rather than having to go outside the hospital grounds. A number of patients who we spoke to told us they were happy to have their own room, however there were complaints about the showers not working as well as they could. In other comments from those that we spoke with, we heard that the food on the ward varied from average to good.

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 and that their views were taken into account.

Patients spoke positively about the activities co-ordinator on the ward and how they are regularly encouraged to get involved with the range of activities on the ward.

The patients we spoke to were aware of their rights. For those detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), these rights include access to advocacy and legal representation. Informal patients were aware that they were free to leave the ward despite the door being locked.

Care planning and treatment and support

During previous visits to 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 planning', and we were told that these standards are being implemented on an ongoing basis, with care plans being audited regularly. We were advised that these standards are currently under review.

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 plans for discharge. A patient-centred model of care planning was clearly evident. We found evidence of patient participation in care plans. However, when a patient chooses not to be

involved or is unable to be involved in care planning, we would expect to see the reasons for this recorded in the patient's plan. 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. We discussed our observations with ward managers on the day of our visit and will follow this up during future visits.

In the files we reviewed, we saw comprehensive risk assessments which were person-centred and showed evidence of review. The files included evidence of multidisciplinary (MDT) meetings and of one-to-one input from nursing staff.

To support ongoing quality of care plans and documentation, there are regular audits undertaken by the nursing team of both paper and electronic documentation. This is a peer-led model with notable improvements in quality and governance. 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 quality improvement is a work in progress and we could see evidence of this improvement.

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 two dedicated consultant psychiatrists for the ward and input from pharmacy, physiotherapy, occupational therapy and a full-time activity support worker. Other input on the ward includes advocacy, a welfare advisor and social work.

The main deficit on the ward is the lack of input from clinical psychology. We were told by the clinical team that having psychology involved in the ward would be beneficial. The team recognise providing a model of care that offers psychological therapies along with psychological formulations would enhance care and treatment for all patient groups, but in particular those patients with a diagnosis of personality disorder. Tayside is in the process of reviewing the care pathway for the treatment of those diagnosed with borderline personality disorder.

During our visit we saw there were a number of patients in the ward who have complex needs, in addition to and as well as, a diagnosis of emotionally unstable personality disorder. Psychological therapy is considered to be a first line treatment for people with these needs and as such, we suggest that these needs could be met better with input from dedicated psychology into Ward 2.

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.

During our visit, we were made aware of a number of patients who were ready for discharge although there were delays due to accommodation issues or because the individuals 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 and mental health officers to identify these needs and plan 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 and mental health officers. However, we also heard that 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 social work 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.

Recommendation 2:

Managers should contact social work peer managers and agree an improved referral pathway.

Use of mental health and incapacity legislation

On the day of our visit, we reviewed a number of patients' files. The paperwork relating to the Mental Health Act was kept in a paper file and was accessible.

We were unable to review forms for consent to treatment and certificates authorising treatment under the Mental Health Act (T2 and T3 forms) as these were not accessible on the day of our visit due to clinical activity. We plan to return to the ward to review these documents. During a previous visit, a concern was highlighted that consent to treatment forms were not filed with prescriptions charts. We were advised by the charge nurse that consent to treatment forms are now filed with prescription charts and are audited on a weekly basis.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions to be regularly reviewed. It also provides the appropriate framework for the review of the restrictions and informs the patient of their right to appeal against these. We found all of the relevant information and paperwork relating to the restriction in the patient files.

When we were reviewing patient files we were looking for copies of advanced statements. The term 'advance statement' refers to written statements, made under ss274 and 276 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 regularly.

During our visit we spoke with a number of patients who were subject to the 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 2. Over the past year, advocacy services have not provided their usual drop-in service, this is due to Covid-19. We discussed this with the staff team on the day and advised them that it would be beneficial for patients to have increased face to face access to advocacy, and to discuss a return to this option with the advocacy service.

Recommendation 3:

Managers should liaise with local advocacy services to progress a return to face-to-face access to advocacy within the ward.

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 to the ward 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. The ward's surge bed is placed in a meeting room. It offers very little space, comfort or privacy and no en-suite bathroom facilities. Apart from a single bed there is no other storage for a patient's personal belongings. 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 constant review and that information regarding the frequency of use of surge beds be sent to the Commission.

Recommendation 4:

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.

On a previous visit to the ward we were made aware of a white board in the main office that contained confidential patient information. Attempts have been made to keep the information on this board to a minimum e.g. each patient's first name only. A film has also been placed over the window to the office which means that it cannot be viewed from the corridor in the ward. However, it was clear on the day of our visit that that the main office is accessed by patients and external visitors. Confidential patient information continues to be displayed on the white board and can be clearly viewed. Whilst we recognise the benefit to staff from having this information easily accessible, we are concerned about the visibility of confidential information. We would like to see alternatives solutions being considered.

Recommendation 5:

Managers should ensure that white boards do not contain confidential information identifiable to patients. Alternative solutions should be sought to ensure confidentiality is maintained.

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 contact social work peer managers and agree an improved referral pathway.

3. Managers should liaise with local advocacy services to progress a return to face-to-face access to advocacy within the ward.

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

5. Managers should ensure that white boards do not contain confidential information identifiable to patients. Alternative solutions should be sought to ensure confidentiality is maintained.

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 heard about the efforts that were made by staff to maintain a therapeutic relationship with patients especially during times of self-isolation. We were impressed to see and hear how staff have continued to provide a quality service despite the numerous challenges including staff shortages. We were impressed about the ongoing commitment to a learning and improvement culture in the ward and multi-disciplinary team and heard of the enthusiasm for taking up training opportunities and investing in staff.

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

When we visit:

- We find out whether 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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