Mental Welfare Commission for Scotland

Report on announced visit to: The Learning Disability Assessment Unit, Carseview Centre, 4 Tom MacDonald Avenue, Dundee DD2 1NH

Date of visit: 24 May 2022 & 15 June 2022

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 over two days.

We visited the Learning Disability Assessment Unit (LDAU) which is a mixed sex, 10-bedded NHS assessment ward for people with learning disabilities. On the day of our visit there were no vacant beds. The unit has a multidisciplinary team (MDT) consisting of nursing staff, psychiatrists, occupational therapy, psychology and physiotherapy.

We last visited the ward on 25 July 2019 and made recommendations regarding care plan audits, staffing requirements and the ward environment.

During our visits we wanted to follow up the previous recommendations and hear how patients, staff and relatives have managed through the Covid-19 pandemic.

Who we met with

We met with and reviewed the care and treatment of five patients and spoke to two relatives.

We spoke with the lead nurse, senior nurse, charge nurse and student nurse on the day of the visit. We also spoke with an advocacy worker.

Commission visitors

Alyson Paterson, social work officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with during our visits told us the staff were nice and they felt safe in the ward. Patients described activities including input from third sector organisations. However patients also told us about feeling bored with not enough to do during the day. We were pleased to hear of patients being supported by advocacy and how helpful this had been to them. We were also pleased to hear that patients have the opportunity to meet with their doctor regularly and that they know who their named nurse is. Some of the patients we spoke to told us that they did not have a copy of their care plan and would like to be more involved with their care planning. Patients told us the ward was noisy. Food on the ward was described as 'not good' and rooms as 'okay'.

The relatives we spoke to had mixed views about the care and treatment on LDAU. Communication with the MDT and participation with their relative's care and treatment were raised as an issues. Delayed discharge was also raised with us. These issues were fed back to appropriate staff either on the day or at subsequent meetings.

Care Plans

Nursing care plans are a tool which identify detailed plans of nursing care. Good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. We made a recommendation during our last visit that care plans should be audited and regularly reviewed. We were pleased to hear that to support the ongoing quality of care plans and documentation, regular audits are carried out and overseen by both the senior charge nurse and the improvement team. The longer term plan is the development of peer-to-peer audits.

During our visits, we saw a range of detailed care plans which detailed interventions informed by the MDT. The care plans addressed both physical and mental health care needs. The care plans we reviewed were generally person-centred although some care plans in the paper files were undated and had no review date.

We were disappointed to find that no care plans were in easy read format. Some of the care plans evidenced patient and/or guardian/POA participation, but this was inconsistent. Whilst we are aware that for some patients, participation in their care planning can be challenging, we would have hoped to see the reasons for limited participation documented and evidence of alternative approaches being considered, for example, Talking Mats.

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

Recommendation 1:
Managers should ensure that there are easy read care plans where appropriate.

Recommendation 2:

Managers should ensure that the level of patient participation is fully documented, regularly reviewed and alternative approaches are used, where required.

Multidisciplinary team (MDT)

A range of professionals are involved in the provision of care and treatment in the ward. This includes psychiatry, nursing staff, physiotherapy and psychology. There is a current vacancy for an occupational therapist (OT). We were told that the OT for the LDAU is often pulled into other wards and this impacts negatively on the patients in LDAU. Other allied health professionals such as dietetics, speech and language and pharmacy input into the ward is on a referral basis. There is open access to social work staff who will attend meetings on request. A new senior charge nurse came into post in the last year and although staffing issues have improved, there is still a shortfall in nursing staff. Bank staff are used, however there is a core group of individual staff who work on LDAU, which ensures consistency of care.

Care records

Information on patients' care and treatment is held both electronically on the EMIS system and in paper files. We found the information in paper files to be out-of-date. We believe there are risks associated with having two systems, especially when one of which does not contain current information.

We were unable to locate some information on EMIS. For example decisions regarding time out of the ward for patients could not be found on EMIS. We were told that these discussions take place weekly and are authorised by the doctor on the ward however we could not find no evidence of this. We were told by patients that they meet regularly with their doctor but again, we could not find a recording of these discussions on EMIS. It was clear that patients were discussed at MDT meetings but it was not clear what the outcome of these discussion were and what decisions were made following an MDT meeting.

We were disappointed to read pejorative language used to describe patients in their care records. Language such as manipulative, sullen and disgruntled are not person-centred descriptions and are not helpful in understanding a patient's needs. It is disappointing that this had not been identified during file audits.

Recommendation 3:
Managers should ensure that all patient information is stored electronically on EMIS to reduce the risks associated with having two separate recording systems.

Recommendation 4:
Managers should ensure that recording in notes meets the Nursing and Midwifery Council (NMC) professional standards and that the use of pejorative language is discontinued immediately.

Use of mental health and incapacity legislation

When a patient is subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), we would expect to see copies of all legal paperwork in the patient files. Part 16 (S235-248) of the Mental Health Act sets out

the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments. We had concerns regarding the practices around the consent to treatment certificates (T2) and certificate authorising treatment (T3) forms and were unable to locate all certificates, where required, meaning that in some cases treatment was being administered without legally authority. We were concerned to find out-of-date T3 forms held in paper files. We were told that the Mental Health Act administration office is planning to develop an audit for authority to treat forms. Whilst we welcome this, we remain concerned about the current system and the lack of safeguards in place.

Where patients are subject to power of attorney (PoA)/guardianship under the Adults with Incapacity (Scotland) Act 2000 (AWIA), we would expect to see a copy of the certificate in the patient's file. In some cases, we did not see copies of certificates on file. It is important that requests for copies are made to either the POA or guardian so that any decisions made are appropriately authorised.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital, including the mechanism for review of the restrictions and informing the patient of their right to appeal against these. Where a patient is a specified person in relation to this legislation, 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. On reviewing patient files, we found individuals who had been subject to restrictions that had not been authorised nor reviewed at the time of our visits. It was not clear from the notes whether or not individuals and/or their Named Person/guardian had been informed of these restrictions.

Recommendation 5:
Managers should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form and a system of regularly auditing compliance with this should be put in place.

Recommendation 6:
Managers should undertake an audit to ensure that all restrictions are legally authorised under specified person's legislation and there is evidence of regular review.

Recommendation 7:
Managers should ensure that the patient and their named person or guardian (if appropriate) is informed of their specified person status and is aware of their right of request review.

The Commission has published a good practice guide on Specified Persons. This guide outlines the principles and best practice in implementing specified persons regulations. It can be found at: https://www.mwcscot.org.uk/node/512

Rights and restrictions

During our visits, the door to the ward was locked. There is a locked door policy in place which is reviewed on a daily basis. Informal patients are advised on admission of their rights in relation to leaving the ward.

During our visits we were made aware that some patients were subject to 'room-based care'. There was no description of what this entailed. Senior nursing staff were unable to provide a description and there were no accompanying care plans. We are concerned that this may in fact be patients being subject to seclusion, however without the safeguards that a seclusion policy would afford. For example, it was unclear to us that if a patient, on room based care, was observed at all times or whether they would they be free to leave their room at any time.

There were patients who had seclusion authorised as part of a treatment plan but this was in their bedroom and the observation was through a window in the door, which did not afford full observation of the room or the en-suite bathroom. This practice has significant risks when an individual, who is distressed, is locked in their bedroom.

We were told that advocacy services are available for patients in LDAU on a referral basis. We were pleased to have the opportunity to meet with one of the local advocacy groups during our visit. There are a number of advocacy services who provide a service to LDAU. Collective advocacy is available for patients in Carseview Centre, but not for those on LDAU due to a different funding stream. Both staff and patients appeared confused regarding the role and remit of the different advocacy groups.

Recommendation 8:
Managers should ensure that there is a clear policy in relation to 'room-based care' which has appropriately documented safeguards and outlines how 'room-based care' differs from seclusion.

Recommendation 9:
Managers should ensure the role and remit of advocacy groups are understood and communicated to staff and patients in the LDAU.

Recommendation 10:
Managers must review the way in which patient observation is carried out in bedrooms to ensure that patient safety is preserved at all times.

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

We heard that occupational therapy staff from Strathmartine Hospital provide input to the ward four days per week. Activities include gardening, art work, food groups and community visits. Additionally, physiotherapy facilitate walking groups and gym sessions. Nursing staff also provide activities on the ward. While on the ward, we saw evidence of activity

programmes. There were jigsaws on the ward, which a number of patients told us they enjoyed doing.

Delayed discharge

During our visits, we were told that nearly half of patients are delayed discharge. This means that they remain in hospital despite being clinically fit for discharge. Some patients have been delayed for over three years. The reasons for these delays include waiting for specialist facilities which require specialist staff.

Whilst the Commission acknowledges that recruiting social care staff is a Scotland-wide issue and can be challenging for complex groups of patients, we are of the view that it is unacceptable that patients remain delayed in hospital for over three years and that discharge planning should begin on admission. Delayed discharges impact negatively on both patients that are currently delayed, as well as on those patients who require admission to LDAU, but are unable to be admitted due to the lack of beds.

The physical environment

The layout of the ward consists of 10 single en-suite rooms. There is a shared lounge, a dining room area and an outside space that is safe and accessible. The ward is staffed for 10 patients however on the day of our visit, it had 11 patients. One patient was in a 'surge bed'. When patients are admitted to the ward and there is no bed immediately available, they are accommodated in a 'surge bed'. As the ward is always at full capacity, the surge bed is in constant use. We were pleased to see that the surge bed was placed in a bedroom which afforded privacy and space.

On the day of our visit, the ward was busy and noisy. A number of patients could be heard expressing their distress. The ward appeared clean and bright with more than one room that patients could use.

We had the opportunity to look in patients' bedrooms. We were pleased to see that they were bright and personalised. In the main, they were clean however we were disappointed to see one bedroom had drink/food on the walls and ceilings. It was unclear how long it had been there. Some patients chose to have their rooms locked, however they do not have their own key.

We were told that the ward was previously decanted to allow for refurbishment to take place. This involved new flooring, new doors and partial ligature work. The ward is not deemed high risk in terms of ligature work. All furniture has been ligature proofed, however shower areas remain an area of risk and there are no door top alarms. Ligature works are carried out across NHS Tayside according to identified risk.

Any other comments

We heard about how challenging the last 18 months has been as a result of the pandemic. It has been particularly difficult for the patient group in the LDAU as in many cases patients could not understand why restrictions, such as reduced visiting, or activities being cancelled, had been put in place. We heard about the efforts made by staff to ensure that patients remained in contact with family.

We were also pleased to hear that there has been a strong and stable staff group who have pulled together and provided mutual support. Students who we met on the ward spoke highly of LDAU and told us they were applying to work on the ward once qualified. We were also pleased to hear about the introduction of the role of a 'floor nurse' that could improve observational practice and provide proactive support for patients.

Summary of recommendations

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Recommendation 2:
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Recommendation 3:
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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
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 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk