

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: 25 July 2019

Where we visited

The Learning Disability Assessment Unit (LDAU) is a 10-bedded NHS assessment ward for people with learning disabilities. It is a mixed sex ward. We last visited this service on 22 March 2018 and made recommendations about care planning, the use of a low stimulus environment, activity provision, the completion of certificates under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), delayed discharge patients and about the ward environment. We received an action plan with actions to be undertaken in relation to each of these recommendations.

On the day of this visit we wanted to meet with patients and look generally at the provision of care and treatment because it had been over a year since our previous visit. We also wanted to get an update on proposed plans to move the LDAU to Murray Royal Hospital in Perth and to see if this planned move is having an impact on patients currently in the LDAU.

Who we met with

We met with and/or reviewed the care and treatment of seven patients and spoke to two relatives

We spoke with the senior charge nurse and during the visit we also met other members of the nursing team and one of the occupational therapy (OT) staff.

Commission visitors

Ian Cairns, Social Work Officer

Claire Lamza, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The patients we met on the day were positive about the care and support provided by staff in the ward and any issues they did mention were discussed with staff and dealt with on the day. One relative told us that the care and treatment being provided by the core support team was very good but that there have been significant issues with staffing on the ward. This was fully discussed with staff on the day and we saw that there was now input from the clinical psychology service to provide guidance in managing stressed behaviour. We also spoke to the senior charge nurse about staffing issues in the ward, and we heard that there have been problems covering nursing rotas. This issue is discussed later in this report.

Care planning and documentation

A nursing care plan is a tool which identifies a detailed plan of nursing care. A good care plan ensures consistency and continuity of care and treatment. It should be reviewed regularly to provide a record of progress being made. We made a recommendation in our last visit report about auditing care plans and we were told about work being done as part of a service improvement work-stream to develop a more person-centred approach to care planning. On this visit we reviewed a number of care plans to look at progress being made enhancing person-centred care plans

There is an electronic records system in place in the ward and some information is still in paper files, with some on the new electronic system. Care plans are in electronic and paper version, supplemented by daily progress notes and records of multi-disciplinary team (MDT) reviews which are on the new electronic system. This did mean that reviewing care plans and looking at how these tied up with MDT reviews and daily progress notes was not simple and straightforward. We felt that the care planning documentation format was good, as it encouraged staff to record information about specific nursing interventions. Care plans which we reviewed were generally person-centred and seemed to relate to each individual patient's assessed needs. They would cover a range of areas depending on assessed needs and in a number of specific care plans we saw how the Roper, Logan and Tierney model of nursing was being applied in practice. (This model of nursing is based on activities of daily living and on promoting independence.) We did note that some individual care plans lacked specific details about nursing interventions and, while plans would include evaluation dates, some plans were undated, or had little or no evidence of evaluation.

Recommendation 1:

Managers should audit care plans and ensure that plans are reviewed regularly with information being recorded about progress made.

Treatment and multi-disciplinary input

A range of different professionals are involved in the provision of care and treatment in the ward. We also saw that independent sector care providers have ongoing input with some patients who are in the ward to make sure that a patient is able to engage in activities in the community during their period of inpatient care and treatment. We also saw that MDT reviews were detailed, identifying issues relevant to the individual patient, with information about the patient's mental health and associated symptoms, with information about future plans. One

minor issue which we did note was that information about the MDT meetings at times was not easy to find in the new electronic records system, but this seemed to be simply about having a consistent approach to how records about MDT reviews are entered into the new system.

In reviewing files we did see that use was being made of pictorial memory stories and the guidelines were in place for supporting individual patients with complex needs, who could present with stressed or distressed behaviours. We felt that the individual guidance and use of pictorial stories would aid communication between staff and individual patients who may have very complex needs.

Staffing in the ward

As mentioned above we heard that there have been significant issues about staffing in the ward, and this was confirmed in discussions with senior nurses in the ward on the day of our visit.

We were told that there will be newly qualified nurses starting in the ward in the near future but there have been difficulties recruiting learning disability nurses to fill posts. Some posts have been filled by mental health nurses but for some time the ward has had to run with a lower ratio of qualified nurses to healthcare assistants than it should have. This has led to a significant use of bank nursing staff. At the same time, as there have been issues filling nursing posts and covering shifts from rotas and at times a significant proportion of patients in the ward will be on enhanced observation. Sometimes this will be in the context of observation when a patient is on an outing from the ward but often enhanced observation will have been assessed as appropriate in the ward, depending on the patient's mental state and whether they may be displaying stressed or distressed behaviours.

Issues about staffing levels in the ward, and about the number of patients on observation, will inevitably have an impact on the provision of care and treatment. We also heard on this visit that for a lengthy period there was no senior charge nurse within the ward and that for part of this period there had also been no charge nurse in post. The Commission is aware of the difficulty nationally in recruiting learning disability nurses but are concerned that senior charge nurse and charge nurse posts were not filled and we feel that the lack of someone in a leadership role in the ward will have prevented planned developments being progressed. We were told on this visit that a workforce tool will be run in the ward looking at nursing workloads.

Recommendation 2:

Managers should ensure, based on information from the planning tool, that staffing requirements for the ward are adequate.

Use of mental health and incapacity legislation

NHS Tayside has a standard form which records when a patient is subject to compulsory measures under the Mental Health (Care & Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Copies of these forms were in files and they detailed the compulsory measures an individual patient was subject to under the Mental Health Act. We did see that the specific Mental Health Act forms relating to one patient were not in his care file. T2 and T3 forms, the certificates authorising treatment under the Mental Health Act, were present and in files where

required, apart from in one case. We were able to confirm in that case that a recent T3 form had been completed but this could not be found. These issues were raised on the day and we emphasised that it was important that documents relating to detentions and to the authorisation of medication are filed consistently.

Where a patient lacks capacity in relation to decisions about general medical treatment a certificate completed under Section 47 of the AWI Act must be completed by a doctor. A certificate is required by law and provides evidence treatment complies with the principles of the AWI Act. We saw Section 47 certificates in place where appropriate, with treatment plans. We did see in one case where an s47 form was out of date and again this was brought to the attention of staff on the ward on the day.

Where patients are subject to guardianship under the AWI Act we would expect to see a copy of the Order in the patient's file. In several cases we did see copies of guardianship orders but in one case a copy of the Order was not on file and it is important that requests for a copy of the Order continue to be made when a guardian is not providing this.

Sections 281-286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. We looked at records involving two patients who had been made specified persons under these sections of the Mental Health Act and we saw that the appropriate forms were in place in both cases.

Rights and restrictions

Patients in the LDAU continue to have good access to independent advocacy support.

On the day of our visit two-thirds of the patients were on observation at least some of the time. Patients who are on constant observation can experience this as a very restrictive intervention but we were pleased to hear from managers on the ward that they were aware of the new Scottish Patient Safety Programme Guidance on improving observation practice (Link: <https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention/>) and that there were plans to implement this new guidance. We welcome this but we do feel that staffing issues in the ward mentioned above need to be addressed before progress can be made implementing this new guidance.

One patient we met on the visit who was subject to compulsory measures under the MHA told us very clearly that they were aware of their rights and that their named nurse had explained these rights to them very clearly.

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

A number of patients in the LDAU are engaging in activities in the community because support workers from community based provider organisations are coming into the ward to take these patients out. People we spoke to told us about a range of activities that they did and we saw that there are art and baking groups, gardening groups, breakfast sessions, art therapy groups

and other groups and activities focussing on physical exercises and escorted walks. We met the OT assistant on the visit and saw how they are recording activities they have planned to do with the patients and we saw timetables in individual care files reviewed. One patient did tell us that they were fed up being in the unit but this seemed to relate more to issues about discharge planning than about activities available for them to engage in. We also felt that while there was good evidence of activity provision in the ward, the provision of structured activities is something which will be directly affected by staffing issues, with staff in the ward having to give a priority to clinical tasks as opposed to engaging people in activities or taking them out of the ward if there are staff shortages.

The physical environment

The garden area for the ward is secure and well-kept and is directly accessible from the main communal lounge. The environment is reasonably spacious and there are areas where patients have a different space to go to if they don't want to go to their own rooms. However, bedrooms and bathrooms are sparse and uninviting and furniture and fittings are very minimal and they are often damaged or worn. The physical environment overall is sparse and clinical, with a very small TV space where many people seemed to congregate. We also heard on the day that some areas in the ward had been closed since April, specifically the snoozeline room and the staff break-room. The Commission understands that the plan is to relocate this ward to Murray Royal Hospital in Perth but we feel that some improvements to the environment can be made in the meantime by looking at opening areas which have been closed where this is possible. We also felt that some of the furniture and fittings can be refurbished to provide a better quality care environment with new furnishings being able to be transferred to a new ward when this move takes place.

Recommendation 3:

Managers should review the ward environment to see how space can be enhanced and furniture and fittings refurbished as soon as possible.

Summary of recommendations

1. Managers should audit care plans and ensure that plans are reviewed regularly with information being recorded about progress made.
2. Managers should ensure, based on information from the planning tool, that staffing requirements for the ward are adequate.
3. Managers should review the ward environment to see how space can be enhanced and furniture and fittings refurbished as soon as possible.

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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