Mental Welfare Commission for Scotland

Report on announced visit to:

Dudhope Young People's Unit, 17 Dudhope Terrace, Dundee, DD3 6HH

Date of visit: 27 September 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.

Dudhope Young People's Unit (YPU) is a mental health facility with twelve in-patient beds for young people aged 12 to 18 years who require a period of in-patient assessment and treatment. It is a regional unit, primarily providing in-patient services for Tayside, Grampian, Highland, Orkney, Shetland and the Western Isles. At the time of our visit, the ward was full.

In the unit, there is input from a multi-disciplinary team (MDT) comprising of psychiatrists, psychologists, nurses, family therapist, dietitian, occupational therapist, physiotherapist, speech and language therapist and social worker. Education for the young people in the unit is provided by a team of teachers.

We last visited the service on 31 August 2021 and made no recommendations.

During our visit we wanted to look at the provision of the care and treatment in the unit.

Who we met with

We met with and reviewed the care and treatment of six patients, and spoke with three relatives.

We spoke with the service manager, psychologist, psychiatrists and nursing staff.

Commission visitors

Alyson Paterson, social work officer

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

We met young people on the ward both on a one-to-one basis and as a group. Those young people who were detained patients were aware of their rights and had access to advocacy and legal representation. Food on the ward was not described positively. We heard complaints about the showers which we had previously been made aware of and understand that there is an electrical fault and work is on-going. The young people we spoke to told us that staff on the ward were approachable and supportive.

Views about care planning were mixed. Some young people felt that they had not been involved in planning their care and that goals were set by others. Most young people were aware of their care plan and some had a copy. The young people that we spoke to told us they had a named nurse. Some young people would like to spend more time on a one-to-one basis with either their named nurse or their doctor. We heard from the service at our end of day meeting that consultant psychiatrist time had been stretched in recent weeks due to annual leave and teaching commitments; and that this may have impacted negatively on young people.

We were pleased to hear that the unit holds community meetings twice a week where young people are able to feedback on any ward based issues.

The relatives we spoke to were overwhelmingly positive about the staff on the unit. Staff were described as “fantastic”, “amazing”, “pleasant” and “welcoming”. We heard from families that staff were interested in both the young person and their wider family and took relatives views into account. Staff made themselves available to talk to families and kept them up-to-date with information about their child. Relatives told us that they were very impressed with the care and treatment young people had been offered, and that staff took the time to get know the young people. The Young Patient’s Family Fund, which funds hotel accommodation when the on-site family flat is not available, was praised by families as it meant they could visit without having to worry about the expense of paying for hotels. Relatives told us they wished there was more on-site accommodation as often it was booked up. The YPU has a family flat which can accommodate one family only. Access to the family flat was seen as an essential part of their child’s treatment plan, allowing them time off the ward, if appropriate, for an overnight stay, whilst retaining the option to ask for support from nursing staff in the unit if required.

We heard from relatives that they found the unit to be homely, clean and fresh with pleasant bedrooms. The sensory room was highly rated. Relatives also liked the range of family rooms and the courtyard garden where they could meet with their child.

We were pleased to hear from relatives that they had participated in their child’s care plan and had been given a copy. Relatives were offered the opportunity to attend ward meetings either in person or remotely, where they as a family were given the opportunity to identify goals for their child to work towards.

Relatives told us that they were a number of activities on offer for young people including yoga, shopping with staff, going to the library, and spending one-to-one time with staff. We

heard that staff take young people out at the weekend, for example to the beach or out for drives.

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 were pleased to hear that to support the ongoing quality of care plans and documentation, care plan audits are carried on a monthly basis. These audits are completed by staff on night shift and fed back to staff on the day shift. Care plans are reviewed twice weekly at team meetings and young people and their families are offered copies of care plans.

During our visit we saw a range of detailed care plans which covered both mental health and physical health needs. We found them to be person-centred and saw evidence of regular review. We were pleased to see communication passports in some young people's files; however, we think it would be helpful if this information was transferred into their care plans. We found inconsistent evidence of patient participation in their care plans. Some care plans were signed by the young person, and we would like to see evidence of young people being actively involved in goal-setting more frequently. If young people are unable to be involved in their own care planning, we would like to see the reason for this being recorded and then it should be regularly reviewed.

We saw detailed and person-centred risk assessments on file. We felt it would be beneficial to have more detail around ways to manage risk, including positive risk-taking strategies.

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 is patient participation in goal setting and that this is recorded in care plans.

Multidisciplinary team (MDT)

A range of professionals are involved in the provision of care and treatment in the unit. This includes psychiatry, psychology, nursing, family therapy, occupational therapy, physiotherapy and social work. A new dietician and speech and language therapist have recently taken up posts in the unit.

MDT meetings are held on the ward, every two weeks and care and treatment is also regularly reviewed under the Care Programme Approach (CPA). CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre.

We were pleased to see MDT updates by staff which began by 'Dear (name of patient)' and then went on to address progress, current issues and outline future goals. These plans were

written in a way that was accessible to the young person; however it was not always clear to see if the patient had attended the MDT meeting and if not, then why not. We raised this on the day of us visit and were advised that this would be reviewed.

We note that staffing levels on the unit have improved since our last visit in 2021; however, there continues to be vacant posts for nursing staff. At times the unit uses bank staff; however, attempts are made to use a pool of regular staff to provide consistency that is beneficial for both patients and staff.

At our end-of-day feedback meeting we raised the issue of young people advising us that they were not seeing their psychiatrist as much as they would like. The service acknowledged that recent pressures on psychiatrists' time due to annual leave and teaching commitments may have had an impact on the young people.

Care records

Information on patients' care and treatment is held mostly electronically on the EMIS system. Some information is held in paper files. We struggled to navigate the two systems and found that some information, for example the records of team meetings, were different depending on whether they were held on EMIS or in the paper file. We are of the view that there are risks with having two systems to store patient information. We fed this back to the service at a subsequent meeting and clarified that the recording of information can be for different purposes. We were advised by the service that the way information is named and stored would be reviewed.

The care records that were reviewed were mainly detailed and personalised. We saw evidence of activities being offered to young people and regular one-to-one support from nursing staff. We also saw evidence of nursing staff working alongside families, for example laundry tasks being undertaken by a young person, a family member and nursing staff. Care records also evidenced involvement from other members of the MDT, for example speech and language team, physiotherapy, dietetics and mental health officers.

Use of mental health and incapacity legislation

On the day of our visit, some of the young people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). When an individual is subject to compulsory measures under 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.

On reviewing the electronic and paper files, all appropriate treatment certificates appeared to be in place and we found no issues with the authorisation of prescribed medication.

Rights and restrictions

Dudhope Unit operates a locked door and had a locked door policy to cover this. We were satisfied this was proportionate in relation to the needs of the patients.

Some young people told us their mobile phones were removed from them overnight and that they had to be up at a certain time the following day in order to take possession of them. Young people found this punitive. We raised this at our feedback meeting and were advised that there is a policy in relation to mobile phone use and that the reason for this practice is to encourage good sleep hygiene.

On speaking to young people and reviewing their files, we saw that young people were accessing legal representation and support from independent advocacy. The young people we spoke to were aware of their legal rights, including their right to appeal against compulsory measures and also the role of a 'named person'. A named person is someone who has been chosen by a patient detained under the Mental Health Act to help protect their interests.

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

There is a school on-site and all young people are encouraged to attend. If young people are unable to attend school, teaching staff will provide input on the unit.

We were advised that the unit provides a range of different activities including an art group, a music group, visits from a therapy dog**,** an action therapy group, a decider skills group which all staff are involved in, yoga and relaxation groups, community meetings, and a daily planning meeting. We also heard about informal activities that take place at the weekend, for example a Sunday quiz night.

However, young people told us that although there were therapeutic activities available, they would like to have more fun things to do such as basketball, football and trampolining. Young people described feeling bored. At the end of day meeting staff advised that football and basketball activities were available to young people, but that on that particular day, young people were awaiting replacement balls due to punctures.

We were told about the 'TQUIP', a short life project running until the end of the year. The aim of the project is to encourage and measure young people's engagement in activities and explore reasons for non-engagement. We look forward to hearing more about this project when we next visit.

Recommendation 2:
Managers should ensure there are a range of activities on offer for young people based around expressed wishes and interests.

The physical environment

The unit is relatively new, purpose built and all bedrooms are en-suite. There is a secure garden space in the courtyard of the building. The unit is bright and welcoming with examples of artwork on the walls as wells as a board identifying staff. There is a large, light and airy gym that can be used for basketball, yoga and trampolining. Since our last visit, a sensory room has been created which we heard was popular and well used.

Any other comments

We heard about the changes in patient flow over the last 12 months with a higher turnover of patients staying on the unit for a shorter time. Every patient admitted onto the unit has an early planning and a formulation meeting which we were pleased to hear about, however it can be challenging to set and implement goals for those who are then subsequently discharged.

Good practice

We were pleased to hear about the improved joint working that is underway between the three Scottish young people's units. Work is ongoing to foster more joint working, including written protocols for when young people are transferred between units.

We heard that the Dudhope team were developing an admission pack for young people and their parents/carers using 'Padlet' which will be accessed digitally. We were impressed by the range of information on the Padlets, which included admission information, settling in, important information, patients' rights and useful resources. We found the format to be accessible for both young people and their families. The Padlets will go live in October 2022.

We also heard about a number of other improvement projects including a piece of work which aims to improve engagement for those with lived experience in terms of decision making. Work is underway to engage with both current and previous young people and their families. Additionally, we were also told about a PDSA (Plan Do Study Act) improvement tool looking at weekend and evening activities for young people of the unit. We look forward to hearing more about both of these projects at our next visit.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is patient participation in goal setting and that this is recorded in care plans.

Recommendation 2:
Managers should ensure there are a range of activities on offer for young people based around expressed wishes and interests.

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.

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