Mental Welfare Commission for Scotland

Report on announced visit to:

Mulberry Ward, Carseview Centre, 4 Tom McDonald Avenue, Dundee, DD2 1NH

Date of visit: 5 December 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.

Mulberry Ward is a 21-bedded, mixed-sex, adult acute psychiatric admission ward in the Carseview Centre; it provides care for patients in the Angus area of Tayside. On the day of our visit there were no vacant beds.

We last visited this service on 6 April 2021 and made recommendations regarding the need for clinical psychology in the ward, the establishment of a seven day home treatment team service in Angus, improving access to the garden space on the ward and refurbishing the bedrooms on Mulberry Ward. Unfortunately the Commission did not receive a response to the recommendations. However we were pleased to hear that a seven day home treatment team has now been set up in Angus.

During our visit we wanted to follow up on the previous recommendations and look generally at the care and treatment in Mulberry Ward.

Who we met with

We met with and reviewed the care and treatment of 11 patients. We also spoke to three relatives.

We spoke with the general manager, head of nursing, lead nurse, senior nurse, consultant psychiatrist, senior charge nurse and other members of the nursing team.

Commission visitors

Alyson Paterson, social work officer

Gillian Gibson, nursing officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients we met during our visit, and the relatives we spoke to, were mostly positive about the staff on the ward. They were described as amazing, out of this world, respectful, reassuring, understanding and supportive. We heard that staff were available to deal with both physical and mental health needs. We heard from relatives that communication from the ward is good. However both patients and relatives raised the issue of staff shortages on the ward, the reliance on agency/bank staff and the impact that this was having on patients. We heard from patients about the use and attitude of some agency staff.

Feedback from patients regarding food on the ward was mixed. We heard the quality was good but that there was not enough variety.

We were made aware of patients on the ward who required specialist treatment and who were unable to access this in Scotland. This has resulted in a plan to transfer these patients to resources in England. The patients and their families raised concerns regarding a move so far away, with one relative describing the plan as appalling and unethical. We spoke to staff at our end of day meeting and were advised that patients had received specialist input on the ward however it was not sufficient, meaning that a move to England was seen as the only option. The Commission has asked to be kept updated.

Care Plans

Nursing care plans are tools which identify detailed plans of nursing care, and good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. NHS Tayside have produced a set of standards, 'Mental Health Nursing: Standards for Person Centred Planning'. We were advised that monthly care plan audits take place on Mulberry Ward. The findings from these audits are good, with improvements targeted at ensuring plans are person-centred.

During our visit, we reviewed patients' care plans on the electronic patient record system, EMIS. The care plans we saw appeared to be split into an initial care plan and a review document. Care plans would benefit from having a detailed summative evaluation. The initial care plan appeared detailed with a thorough care statement. However, the review document was difficult to read, contained historical information and could have been more detailed in terms of the effectiveness of interventions. Reviews would benefit from being amalgamated into the initial care plan document, as is the practice in other in-patient wards in Tayside.

We saw and heard inconsistent evidence of care plans being shared with patients. Some patients told us they had been involved in their care planning and had copies of their care plans whilst others were not aware of having a care plan and had not seen a copy.

Overall we were impressed with the quality of the care plans we saw. The care plans we reviewed had clear goals and interventions and we found them to be holistic, person-centred and detailed.

Recommendation 1:
Managers should ensure that patients are involved in their care plan and receive a copy. If patients chose not be involved, this should be documented.

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 team (MDT)

The ward has a multidisciplinary team (MDT) involved in the provision of care and treatment in the ward; the team comprises of nursing staff, psychiatrists, occupational therapy (OT) staff, physiotherapist, activities support worker, pharmacist, discharge support workers and a physical health psychologist.

During our last visit to Mulberry Ward, we made a recommendation that plans should be progressed to have dedicated clinical psychological input into the ward. Despite this recommendation being actioned, a vacancy remained for a dedicated psychologist for those patients that present with complex issues, and who would benefit from psychological input. A referral system to psychology was in place on an individual basis. We understand that nursing staff had been trained in safety and stabilisation, which aims to support patients who have experienced trauma. A number of staff have also had decider skills training which helps patients to manage their own thoughts, feelings and behaviours. Although these interventions are welcome, during our visit we saw and heard about the need for a dedicated clinical psychologist on the ward.

Recommendation 2:
Managers should continue to work towards establishing a dedicated clinical psychologist in the ward.

We were told that Mulberry Ward continued to have registered mental health nurse (RMN) vacancies. This has resulted in agency staff being block booked and also bank staff being used. Patients told us that staff vacancies have impacted negatively on them, for example, this has resulted in reduced one-to-one time with nurses. The ward had been trialling funding for the existing Band 3 nursing assistants to train as Band 4 nurses. We were pleased to hear that there had been significant interest in this initiative.

We were told that both of the psychiatrists on the ward were locums however, they have long-term contracts. We were pleased to hear that the ward had a dedicated ward clerk that has freed up time for nursing staff. We were also pleased to hear about the creation of a discharge support worker as a result of a test of change. Discharge support workers work with patients on admission through to six weeks post-discharge.

Care records

Information on patients' care and treatment was held on the EMIS system. Some information was difficult to locate, such as the name of the patient's doctor or social work mental health

officer (MHO). The daily progress notes regarding patient care and treatment lacked detail and tended to be descriptive, for example describing the patient as having a "low profile on the ward". There was inconsistent evidence of specific interventions, however we did see some evidence of one-to-one support and other nursing interventions.

Progress notes recorded input from other disciplines. We were pleased to see regular input from OTs on the ward and interventions such as grounding techniques that were recorded. Daily progress notes contained information regarding MDT meetings. We heard that MDT meetings were held on the ward on a weekly basis. When we reviewed these, there was inconsistent records of attendance and contribution at these meetings. The patients we spoke to told us they were invited to MDT meetings along with their family, if appropriate, however this was not always clear from records. We would like to have seen evidence of patients being invited to MDT meetings and for it to be recorded if they chose not to attend. Some of the MDT records we reviewed clearly documented a patient's status, diagnosis, treatment, progress and forward planning; others were less detailed with no clear actions identified.

Recommendation 3:
Managers should ensure that there is a record of attendance and contribution for all MDT meetings and that reason for non-attendance is documented.

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, in sections 235 to 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, and who are either capable or incapable of consenting to specific treatments. We reviewed the consent to treatment certificates (T2), and the certificates authorising treatment (T3) for all patients for whom this was required.

We found several issues that we addressed during our visit. In one case intramuscular (IM) medication was prescribed but was not covered by either a T2 or T3 certificate. We were also unable to locate a signed patient consent form which should accompany a T2 form. In a further case we were able to locate a T2 with signed consent however the patient had only consented to one medication and was being prescribed two. We also found medication prescribed which was not authorised by a T2 or T3.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

We reviewed patients' medication prescription sheets which were contained in a plastic wallet. We found information inappropriately stored in ripped folders which resulted in information being difficult to locate. We also found documents pertaining to patients' physical health which were ripped and disorganised. We also noted that the medication prescription sheet had additional notes written in the margin which was impossible to read and confusing. The Nursing & Midwifery Council (NMC) have set standards in relation to the storage of

documentation. The current storage system did not meet these standards and had the potential to lead to medication errors.

Recommendation 4:
Managers and the responsible medical officer must ensure that all psychotropic medication is legally authorised and record a clear plan of treatment. Regular audits should be undertaken to ensure the correct authorisation is in place and that medication prescription records are legible and stored appropriately.

Rights and restrictions

Mulberry Ward operates a locked door and has a policy to cover this. We saw a notice at the entrance to the ward informing visitors about the policy. We were satisfied that this policy was proportionate in relation to the needs of some of the patients on the ward.

We heard from one informal patient who was unsure of their proposed treatment. It was clear from the records that staff had taken time to explain the risks and benefits of the treatment, and that no treatment was given until the patient had provided their informed consent.

However, during our visit we spoke to a number of informal patients who were being prevented from leaving the ward when they requested to do so. This group of patients did not appear to understand their rights as informal patients. These patients had restrictions placed upon them; for example, requests to attend the hairdresser or a visit to the patients' garden had been refused. We saw it documented in an informal patient's notes that the patient had asked what would happen if they tried to leave; they were advised that it is likely they would be detained. This practice could be considered 'de-facto detention', meaning that this group of patients may be unlawfully detained, without having any of the safeguards that formal detention would bring.

Recommendation 5:
Managers should ensure that all informal patients are fully aware of their rights and that for any restrictions that are in place, informed consent is recorded. Managers should also ensure that all staff understand the distinction between informal and detained patient status.

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

When we are reviewing patient files we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and they are written when a person has capacity to make decisions on the treatments they want or do not want in the future. Health boards have a responsibility to promote advance statements. We were pleased to hear that one patient had an advance statement. However if a patient chose not to complete an advance statement, we would like to see the reason recorded along with evidence of the discussion being revisited.

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. It also provides the appropriate framework

for the review of the restrictions and informs the patient of their right to appeal against these. 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, that the need for specific restrictions to be recorded and regularly reviewed. On reviewing patients' files, we found one case where a patient was made a specified person, however there was no clear reason for this documented. We fed this back to staff on the day of our visit.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

Activity and occupation

We were pleased to hear that the ward has a full-time activities support worker who was highly praised by both staff and patients. We were told that patients could attend the gym and cycling sessions with the physiotherapist. We also heard about the plans to purchase e-bikes. We heard from patients that there were regular activities offered such as baking, relaxation, bingo, smoothie making, quizzes and board games. We saw in patients' notes that there were discussions between the activity support worker and patients, outlining activities that were on offer.

Despite this, some patients told us they were bored. Some patients found the activities too passive and wanted something more active to be available to them. One patient asked for a suggestion box for activities. Whilst it is acknowledged that it is challenging to offer activities that will suit a wide range of interests, we would like to see a range of person-centred activities on offer to patients.

The physical environment

The layout of Mulberry ward consisted of single en-suite rooms with a male and female corridor. The ward had a lounge area, a dining room and a small art room. Mulberry ward was on the first floor. Although it faced onto the garden, there was no direct access from the ward. A significant number of patients and relatives complained about the lack of easy access to the garden. Patients had to be escorted by nursing staff to the garden and are asked to stand in a fenced off area known as 'the cage'; patients felt frustrated and distressed by this. Staff shortages has meant that visits outside did not happen as regularly for those in Mulberry Ward, as compared to other admission wards in the Carseview Centre.

Recommendation 6:
Managers should continue to review how access to the garden space can be improved for patients in Mulberry Ward.

On the day of our visit, the ward seemed calm. We enjoyed looking at the Mulberry Bush, which is artwork of a tree on the wall where those who were discharged could put a positive message for those newly admitted. However, overall we did not find the ward to have a homely feel; instead we found it to be clinical and uninviting and felt that the ward environment would benefit from improvements to make the ward more comfortable.

We saw that the en-suite bathrooms suffered from mould and peeling paint. During our last visit, we made a recommendation regarding the refurbishment of patients' rooms. We were pleased to hear that there was a plan in place to refurbish bedrooms and en-suite bathrooms. The programme of works was delayed due to the Covid-19 pandemic but should commence imminently. We look forward to seeing how the work has progressed on our next visit. We heard all anti-ligature works had been completed.

During this visit and our previous visit, we heard from patients and relatives expressing their unhappiness with how far they had to travel from parts of Angus to Mulberry Ward in Dundee. This was particularly challenging for relatives without their own transport and meant that some patients missed out on seeing relatives due to the distance that had to be travelled.

Any other comments

We heard that there were two patients on Mulberry Ward whose discharge from hospital was delayed; they have continued to remain in hospital despite being clinically fit for discharge. One patient had been delayed for 10 weeks and the other for two weeks. These delays were due to housing and support requirements. The Commission is of the view that discharge planning should begin as early as possible after admission to prevent patients having to remain unnecessarily in hospital. We were pleased to hear that since the discharge support worker role was developed, discharge planning in Mulberry Ward begins on admission.

Summary of recommendations

Recommendation 1:
Managers should ensure that patients are involved in their care plan and receive a copy. If patients chose not be involved, this should be documented.

Recommendation 2:
Managers should continue to work towards establishing a dedicated clinical psychologist in the ward.

Recommendation 3:
Managers should ensure that there is a record of attendance and contribution for all MDT meetings and that reason for non-attendance is documented.

Recommendation 4:
Managers and the responsible medical officer must ensure that all psychotropic medication is legally authorised and record a clear plan of treatment. Regular audits should be undertaken to ensure the correct authorisation is in place and that medication prescription records are legible and stored appropriately.

Recommendation 5:
Managers should ensure that all informal patients are fully aware of their rights and that for any restrictions that are in place, informed consent is recorded. Managers should also ensure that all staff understand the distinction between informal and detained patient status.

Recommendation 6:
Managers should continue to review how access to the garden space can be improved for patients in Mulberry Ward.

Good practice

We were pleased to hear about the 'safe-wards' initiative and read the accompanying newsletter. The aim of this initiative was to create therapeutic interventions such as positive words, talk down and reassurance supported by an intervention champion. We heard that prone (face down) restraint had not been required on the ward since the introduction on this initiative. We were pleased to hear this as certain types of physical restraint, for example prone restraint, carries increased risks for patients. Feedback from the staff regarding 'safe-wards' had been positive.

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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