Mental Welfare Commission for Scotland

Report on announced visit to:

Flats 1, 2 and 3 at Strathmartine Centre, Dundee, DD3 0PG

Date of visit: 27 April 2023

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.

Flats 1, 2 and 3 are learning disability in-patient units at the Strathmartine Centre. Flat 1 is a low-secure environment for male patients with learning disabilities and offending behaviour. Flat 1 is staffed for nine patients however at the time of our visit one of the patients was in Flat 2. Flat 2 is an empty ward that is currently being used by one patient from Flat 1 and one patient from Flat 3. Flat 3 is the behavioural support and intervention unit (BSIU) which is staffed for nine patients one of whom is in Flat 2. Flat 3 provides care and treatment to male and female patients with learning disabilities who can display stressed and distressed behaviours.

On the day of our visit, neither unit had vacant beds.

We last visited this service on 9 December 2020 and made recommendations regarding the auditing of care plans, ensuring patient involvement in care planning, obtaining copies of guardianship certificates, ensuring mental health act paperwork was up-to-date and the need for an environmental audit in Strathmartine Centre.

We were unable to locate a response from the service regarding the previous recommendations made; this may have been due to the Covid-19 pandemic.

Concerns had been raised with the Commission regarding the number of assaults on staff and the impact this was having on them. We were also aware of the use of seclusion and the appropriateness of this. On the day of our visit we wanted to follow up on the previous recommendations, look more at the issues that had been raised with us and hear generally from patients and relatives about their care and treatment.

Who we met with

During our visit we met with four patients and reviewed the care and treatment of six patients. We also met one relative.

We spoke with the senior charge nurses (SCNs) on both units, the senior nurse, the locum psychiatrist, pharmacist, and, at a subsequent feedback meeting, we met with the general manager, the lead nurse, the forensic psychologist, consultant psychiatrists, pharmacy technician and an occupational therapist.

Commission visitors

Alyson Paterson, social work officer

Claire Lamza, executive director (nursing)

Dr Arun Chopra, executive director (medical)

What people told us and what we found

Care, treatment, support and participation

During our time on the units, four patients chose to speak to us. Patients spoke positively about staff, describing them as 'very nice' and 'good'. Patients told us they knew they had a named nurse and some of them had regular one-to-one meetings with them. Some of patients we spoke with told us that they did not feel safe on the ward. This appeared to be due to the level of patient acuity in the unit. Overwhelmingly patients complained about the standard of the food, specifically that it was often cold.

Some patients we met during our visit were not able to engage in a discussion about their care and treatment due to the extent of their cognitive impairment. However, we did spend time in all of the flats, speaking to patients, and where appropriate, we observed the care and treatment of individuals. We found there to be some meaningful interactions between patients and staff, and it was clear that the staff group knew the patients on the ward very well.

The relative we spoke to during our visit told us about staff shortages and the changes in staff which were unsettling. Issues were raised regarding patients' belongings going missing especially clothes not being returned from the hospital laundry.

Many of the issues raised by patients were in relation to their personal concerns. We provided advice on the day of our visit and, where appropriate, fed back any concerns to staff.

Patient records

At the time of our visit, information on patients care and treatment was held in two systems. EMIS, the electronic patient record system, recorded care plans, risk assessments and multi-disciplinary team (MDT) documentation. Paper files held mental health act and incapacity documentation. There are inherent risks in having two systems to record information and ideally all information should be held electronically, as is the case in other parts of NHS Tayside. The patient records we reviewed were detailed, clear and comprehensive and provided daily descriptions of patient presentation and activities undertaken. We saw evidence of patient's healthcare needs being addressed and good liaison with other health professionals.

Nursing care plans

Nursing care plans are tools that identify detailed plans of nursing care, and robust 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 pleased to hear that to support the ongoing quality of care plans and documentation, monthly audits were undertaken in the units. We heard that the service plans to develop peer to peer audits undertaken by nursing staff from another unit. We look forward to hearing more about this when we next visit.

On our last visit to Strathmartine in 2020, we made recommendations regarding care plan auditing and patient involvement in care planning. During this visit, we reviewed care plans that were held on EMIS. There were a number of care plans which addressed both physical and mental health needs. We found them to be very detailed, person-centred and there were

clear interventions recorded. We got the sense that staff knew the patients very well. We saw evidence that care plans were discussed with patients and that they were reviewed.

In the care plans that we reviewed, we found inconsistent evidence of patient and relative involvement. Although we saw records of some care plans being discussed with patients, we were unable to find evidence of patients/relatives contributing to the care planning process. We were disappointed to find that no care plans were in an easy read format. Some of the patients who we met with during our visit had a copy of their care plan with them. Unfortunately some patients did not know what a care plan was and/or they were not able to understand the content due to the level of detailed information contained within them.

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.

Recommendation 1:
Managers should ensure that the easy read care plans are developed, 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.

We found detailed information regarding the risks identified, and the management of these recorded in each of the care plans. Where there were specific risks in relation to other legislation, such as the Criminal Procedure (Scotland) Act 1995 (CPA) and Multi-agency public protection arrangements (MAPPA), we found information relating to these, and this was incorporated into the care plan.

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)

A range of professionals were involved in the provision of care and treatment in the units. This included nursing staff (both mental health and learning disability nurses), consultant psychiatrists (not on-site at all times), psychology, pharmacy, occupational therapy (OT), a dedicated art therapist, mental health officers (MHOs) and psychology. We heard that a dietician visited the units on a monthly basis. Advocacy were based on-site. We were told that the speech and language team (SaLT) had a limited presence on the ward despite there being a clear need from the patient group on the units. We were advised that referrals to SaLT could take up to six weeks to be actioned.

We heard that there were a number of vacant posts across the units. Two locum psychiatrists were due to leave their posts in May and the service was in the process of recruiting. We heard that there was a 51% vacancy rate for registered nurses. This resulted in constant use of agency and bank staff. Two registered nurses were employed through an agency for a six-month period to assist with the shortfall in staff and to provide a level of continuity to the

units. Unfortunately, during the last recruitment drive for registered nurses there were no suitable candidates. We heard from staff, patients and relatives that staff shortages had had an adverse impact on the units. We read in one patient's notes that an Adult Support and Protection (ASP) investigation was being considered as a result of concerns raised by staff regarding poor levels of staffing in the unit and due this, there was an inability to meet basic care needs for the patient. We also read about the lack of consistency across the staff group that had had a negative impact on a patient's care. In March 2023, 200 shifts had been filled by either agency staff or by staff working overtime. A reduced staff skill mix had resulted in burnout and high sickness rates. The service was attempting to minimise the impact of this on patients by using nursing staff that have retired and returned to work on every shift.

We heard that clinical team meetings were held on a weekly basis; MDT meetings were held monthly. We saw that a range of professionals were involved in the MDT meetings including psychology, OT and physiotherapy. MDT meetings were recorded on EMIS. We found these to be brief with no agreed actions or plans to take forward. We saw inconsistent evidence of patient participation in MDT meetings; it was not always clear if patients attended, and if their views were sought prior to the meeting. If they chose not to attend we could not see this recorded. Of the patients we spoke to during our visit, some were aware of the MDT meetings taking place, and some patients told us that they got the opportunity to meet with their psychiatrist after the meeting had taken place.

Recommendation 3:
Managers should ensure that MDT meetings are fully recorded evidencing patient/relative involvement.

We saw that care and treatment was also reviewed under the Care Programme Approach (CPA) for some patients. The 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 CPA used on the units and found the information contained in this document to be accessible, informative and containing clear evidence of patient participation.

There were CPA minutes that provided comprehensive information of individual's background, legal status and progress to date, activities that the individual engaged in and, reports from each member of the MDT involved in the patient's care, along with a list of actions. There was also a record of concerns and questions that the patient had presented to the attendees, and a note that these were then discussed with the individual.

Use of mental health and incapacity legislation

On the day of our visit, many of the patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) in the units. When a patient is subject to compulsory measures under the Mental Health Act, we would expect to see copies of all legal paperwork in the patients' files.

Part 16 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. Treatment must be authorised by an appropriate T2, T3 or T4 certificate to evidence capacity to consent. On reviewing the electronic and paper files we found the electronic versions for these stored on EMIS.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (AWIA) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of Act. On reviewing patient files, we again found that there was an uploaded version of s47 certificates on EMIS.

Where patients are subject to power of attorney (PoA) or guardianship under AWIA, we would expect to see a copy of the certificate in the patient's file. On our last visit to Strathmartine we made a recommendation that:
"Managers should ask guardians to provide a copy of any guardianship order granted and to make sure that this is filed appropriately."

Although we were able to locate some guardianship certificates, we did not see copies of all certificates on file. We were advised that in some cases staff have difficulty obtaining this information. The Commission is of the view that it is important that requests for copies are made to either the POA or guardian and any refusals or delays are escalated to the local authority. This is to ensure that any decisions made by proxy decisions makers are legally authorised.

Recommendation 4:
Managers should ensure that when a welfare proxy is in place for a patient, a copy of the document stating the powers of the proxy should be held in the case notes.

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, the need for specific restrictions to be regularly reviewed and that all documentation is kept up-to-date.

On our last visit to Strathmartine we made a recommendation that:
"Managers should ensure that systems are in place to make sure that all Mental Health Act documentation is up to date and that any restrictions are appropriately authorised."

On reviewing patients' files, we found one case where an individual had been subject to restrictions that had not been authorised nor reviewed at the time of our visit. It was not clear from the notes whether or not the individual and/or their Named Person/guardian had been informed of these restrictions.

Recommendation 5:
Managers should ensure that all restrictions are legally authorised under specified person's legislation and there is evidence of regular review.

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

Rights and restrictions

Due to the complex needs of the patient group in the units, a locked door policy is in place. We were satisfied that this was proportionate in relation to the needs of the patient group.

When we review 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, 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 advised that the patients in the BSI unit did not have the capacity to make advance statements. We were pleased to see that a number of patients in Flat 1 had advance statements and we were able to locate copies of them in the paper file.

We were informed that all patients detained under the mental health act were referred to advocacy and were pleased to hear that advocacy services were based on-site and visit the units on a weekly basis. All the patients we spoke to were aware of their rights and had accessed advocacy, had legal representation and were aware that they could nominate a Named Person.

On the day of our visit, we were concerned to hear that 60% of patients in BSI unit and 34% of patients in Flat 1 had discharges that were delayed. This means that these patients have remained in hospital despite being clinically fit for discharge. We heard this that this was mainly to do with the lack of appropriate accommodation and social care providers. The Commission is of the view that discharge planning should begin as early as possible, preferably on admission, to prevent patients having to remain unnecessarily in hospital. One patient had been delayed for over four years. We would like to see managers working closely with their colleagues in social work to ensure a solution to this issue can be found.

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

During our visit, we found a broad range of activity provision in the units and on-site. This included: a well-attended pallet workshop where patients could develop woodworking skills; a gardening project on the extensive on-site area, art therapy from the dedicated therapist, pet therapy and self-catering in the OT kitchen. In the flats there is access to games, arts and crafts and pampering sessions. We heard that music therapy was due to re-start after the funding had been stopped. We were told that in the BSI unit, one-to-one activities take place. For patients in Flat 1, activities were timetabled and there were more opportunity to take part in community based groups and college courses.

All of the patients who we spoke to on the day of our visit told us that they had a range of activities that they took part in and enjoyed. One patient told us that they felt bored at the

weekend. Patients told us that staff ask them what activities or therapies they would like to take part in and try to accommodate individual interest. Some patients told us that had an activities care plan. We were pleased to hear that some of the patients from the BSI were having a day out to an animal park on the day of our visit.

We found clear evidence of activity in the notes we reviewed. We were impressed with the range of activities that were documented in the patient's care record, and these included a range of psychological therapies, activity-based sessions such as a walking group, community-based activities including trips using public transport and attending local football games. There was a strong focus on rehabilitative activities including money management, meaningful occupation such as placements at the local college and structured sessions with independent care providers who were likely to be involved when an individual leaves hospital.

The physical environment

The flats at the Strathmartine Centre were purpose built in the mid-1990s for a different patient group to the ones occupying it when we visited. We were told that the site is not ideal as it requires upgrading in all areas. During previous visits to the units we were advised that the wards at Strathmartine Cenre would move to Murray Royal Hospital in Perth. On subsequent visits we heard that this planned move was not being progressed.

During our last visit to the Strathmartine Centre in 2020, we made a recommendation that an environmental audit should be undertaken and refurbishment work completed as soon as possible. Unfortunately, we heard that this recommendation had not been actioned. A decision has not yet been made by the service as to whether the flats will be upgraded, moved to an alternative site or if a purpose built alternative is required.

During our visit, a number of issues were raised by staff and patients regarding the accommodation. The most concerning of these was the pin-point alarm system which has been failing for the last six years. This meant that staff were not aware of incidents in other parts of the site and had no confidence that if they activated the alarm it would be responded to. Additionally, there had been numerous false activations. Unfortunately, all of these issues have had an impact on staff confidence.

This issues and concerns with the alarm system has been escalated as a high risk concern and radios provided as an interim measure.

Recommendation 6:
Managers should, as a matter of urgency, address the issue of the failing pin point alarm system. Work should be progressed to either fix the current system or, if this is not possible, provide a new alarm system.

Flats 1 & 3 were very similar in layout and were split into east and west wings. All bedrooms had an en-suite toilet and sink but no shower. There was one communal shower for each wing. The patients we spoke to during our visit complained about the limited shower facilities and said that it was particularly difficult during the week when they had scheduled therapeutic activities to attend and had to wait to shower. The communal shower opened onto a corridor. We think this is a dignity and privacy issue given that staff, patients and visitors use this corridor. Despite being treated, the showers continued to show evidence of mould.

One patient showed us their room. We were told that the rooms are hot, the window was broken and the blind could not be opened resulting in it being very dark.

Overall, the flats appeared cramped, dark and unhomely. This is an issue given that many of the patients have been in hospital for a significant number of years. All three flats have access to outside space which patients can use, if appropriate.

Both Flat 1 and BSI unit had an office located at the entrance. There was a white board on the office wall that contained patient information. Although only patient's initials were used, we think there is an issue of confidentiality, given that it can be seen by visitors, and we suggested on the day that a cover is used.

During our visit we spoke to the pharmacist. We were told that the treatment rooms were too small and did not allow space for patients to be given the option to have their depot injection (if they were on one) in any place other than their rooms. There was also an issue with privacy and with the heat in the treatment rooms that put medications at risk, as the rooms could go past recommended heat levels in the summer months. The cupboards used did not meet standards. There was also an issue with wifi that means the pharmacist could not enter data contemporaneously. In short, we heard that the treatment rooms were not fit for purpose.

All of the patients who we spoke to during our visit, complained that the flats were noisy. Some patients in Flat 1 complained of feeling unsafe. This was due to the level of patient acuity.

We were advised that anti-ligature work was still to be carried out. This was sitting as red on the risk register.

During our visit we were made aware of a number of patients who had seclusion authorised as part of their treatment plan. We saw that these patients had seclusion records in their file and they had been completed fully. Some patients were nursed using CCTV and were unable to socially interact with staff or other patients. Some of these patients were in long-term seclusion. We were told that these group of patients required a low-stimulus environment which the flats could not provide.

We noted in patients' files references to the Mental Welfare Commission's good practice guide on the 'Use of seclusion'. We were of the view that seclusion, as defined in our good practice guide, did not cover the situations that we observed whereby individuals were in longer term isolation. We were also unsure about the wider benefit to individuals who were in longer term seclusion/isolation and the impact of this in relation to any progress that they could make towards their goals and outcomes.

Recommendation 7:
Managers should develop a longer-term seclusion/isolation policy that clearly defines how it will be monitored. This policy should include how and when CCTV is used to monitor individuals.

Recommendation 8:
Managers should ensure that there are clear goals, defined in individual care plans, that set out the benefit and progress towards achieving these goals for those who are in longer term isolation/seclusion.

Recommendation 9:
Managers should, as a matter of urgency, make a decision regarding the estate and whether the current estate will be upgraded or source an alternative be that purpose built or a move to more suitable accommodation**.**

Any other comments

We heard that patients on the units were unable to access annual health checks. These health checks are linked to GP contracts. We were told that as patients were unable to attend the local GP surgery for these checks to be undertaken, and a practice nurse had visited the units. Unfortunately, the practice nurse did not have the level of skill to complete these health checks. The service planned to upskill nursing staff in order for them to carry out annual health checks. We hope that these checks have been carried out when we next visit.

Summary of recommendations

Recommendation 1:
Managers should ensure that the easy read care plans are developed, 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.

Recommendation 3:
Managers should ensure that MDT meetings are fully recorded evidencing patient/relative involvement.

Recommendation 4:
Managers should ensure that when a welfare proxy is in place for a patient, a copy of the document stating the powers of the proxy should be held in the case notes.

Recommendation 5:
Managers should ensure that all restrictions are legally authorised under specified person's legislation and there is evidence of regular review.

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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.

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