Mental Welfare Commission for Scotland

Report on announced visit to:

The Learning Disability Assessment Unit, Carseview Centre, 4 Tom McDonald Avenue, Dundee DD2 1NH

Date of visit: 23 November 2023

Where we visited

The Learning Disability Assessment Unit (LDAU) is a mixed-sex, 10-bedded assessment unit for people with learning disabilities. On the day of this visit there were no vacant beds.

We last visited this service in May and June 2022 made 10 recommendations that related to accessible and easy read versions of care plans, individual's participation in their care, storage of records on the electronic system, record keeping in line with Nursing and Midwifery Council (NMC) standards, medication and restrictions being delivered within the legislative requirements, the role of advocacy, and the use of observation and room based care being clearly defined. We wanted to hear how the recommendations had been progressed in the services and to hear about the experience of care in the unit. Since then the LDAU has seen a responsible medical officer (RMO), senior nurse and charge nurse appointed to post.

Who we met with

We met with three individuals in person and reviewed four care records. We also met with two relatives.

We spoke with the lead nurse, senior nurse, and charge nurse. We were advised the acting senior charge nurse was on annual leave.

Commission visitors

Gordon McNelis, nursing officer

Lesley Paterson, senior manager (East Team)

Alyson Paterson, social work officer

What people told us and what we found

Care, treatment, support and participation

The individuals we met with told us that LDAU staff "really go out their way to help people", were "very supportive" and "keep me safe". We observed nursing staff having a good understanding, and a way of working with individuals with enhanced communication needs; we were pleased to see their needs identified and addressed during periods of distress.

Individuals told us they found the regular one-to-one meetings with their named nurse and doctor "useful" and "good", and described how staff approach them to gather their views prior to the weekly multidisciplinary team meetings (MDT). Some of the individuals we spoke with said that there was limited feedback from MDT discussions and they would have liked to hear more about the MDT response to their views, and for them to be made aware of future plans while receiving care and treatment in LDAU.

Delayed discharges

There were four individuals' whose discharge had been delayed for an extended period of time. The term 'delayed discharge' refers to when a person, who is clinically ready for discharge from inpatient hospital care, continues to occupy a hospital bed usually because of delays in securing a placement in a more appropriate setting. Whilst the Commission acknowledges that some issues remain out with the control of the health authorities responsible for the care of individuals, discharge planning should begin on admission. Delayed discharges impact negatively on both the individual who is delayed, as well as on those individuals who require admission to specialist areas, but are unable to be admitted due to lack of beds.

The LDAU has been working together with Dundee Health and Social Care Partnership (HSCP) to reduce delays. In addition to lack of available beds in local and specific out-of-area services, we were told of other factors contributing towards the delay in discharges, such as the lack of trained staff in third sector organisations with the skills and expertise to work with individuals in the community. We were told that the LDAU and Dundee HSCP senior managers meet monthly to identify the availability of specialist placements and monitor developments in these areas.

Care records

Information on individuals' care and treatment was held in the electronic record system, EMIS. Our review of the information on the system showed the quality of the records to be variable, with some continuation notes providing a detailed clinical description of each individual's mental state and their presentation on that day, while other entries only gave a basic account. The Commission considers that a descriptive account which records comprehensive clinical information and gives a clear overview of whether an individual's mental health is showing signs of improvement, deterioration or is unchanged, is useful in gaining a better understanding of an individual's recovery and of their care.

We saw recorded evidence of the named nurse engaging with individuals to gain their views on care plans reviews, but found this one-to-one discussion was inconsistently recorded in

the continuation notes. We would expect that a record of all contact between the individual and their named nurse to be included in all continuation notes, as it provides a better understanding of the ongoing progress of the individuals' views.

We were pleased to find that risks which were identified during the admission assessment process were included in fuller risk assessments and care plans; we found these gave a good understanding to those who were unfamiliar with each individual's historical and current circumstances.

We were told that a newly designed learning disability MDT meeting proforma had recently been trialled as part of a test of change and with additional changes expected, however, despite this form providing the opportunity to record relevant information, we noted some sections were incomplete. The form provides the MDT with the opportunity to document a summary of each team meeting, to provide a collective response to each individual's care, treatment, and needs, and to give a clear account of current and future plans. We would like to see these areas being fully completed for future Commission visits.

Recommendation 1:
Manager should ensure that one-to-one discussions between individuals and staff are consistently documented in the care records.

Recommendation 2:
Manager should ensure that MDT meeting document is fully completed.

Care plans

We reviewed care and treatment plans and saw examples that were person-centred, descriptive and demonstrated a good awareness of individual needs and responsive interventions. We found care plans linked with admission and risk assessments which included specialised care plans that were well-explained and focused on specific concerns, for example, prevention of harm and use of seclusion.

We were disappointed to find care plans were not in easy read format, as this was a recommendation from our previous visit. We were informed that the initial plan to this recommendation was for a short-life MDT working group that linked in with speech and language therapy (SALT), to develop easy read care plans for all individuals. However due to the LDAU's reduction in access to SALT, this recommendation remained outstanding. We would expect this to be actioned as soon as possible and for the Commission to be made aware of progress in relation to this recommendation.

We noted a lack of relatives/carer involvement with care plans. This involvement and valuable input, where appropriate, could ensure that care plans are more inclusive, provide more comprehensive information, specifically for those individuals who may have difficulty with communicating or expressing their views.

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 3:
Managers should ensure that there are easy read care plans where appropriate.

Recommendation 4:
Managers should ensure that relatives and carers are involved with care planning, with particular consideration to be given to those individuals who may have difficulty with communication.

Multidisciplinary team (MDT)

We were told of challenges experienced in the LDAU in relation to changes in staff. The quality improvement and practice development team has provided support to the MDT to assist in improving the quality of the care. We were told of additional recruitment to the MDT that has resulted in the permanent recruitment of a consultant psychiatrist, a senior nurse to learning disability services and a charge nurse. There were also plans for an additional charge nurse to be recruited to the LDAU. Senior managers felt these additional posts had brought a beneficial focus and valuable input to the MDT.

We were told that Dundee HSCP had concerns with the lack of communication which impacted on planning packages of care for individuals discharged from LDAU. In response to this, an improvement plan has been implemented with the LDAU and has increased joint working with Dundee HSCP. The improvement plan was signed off by the nurse director for mental health. Actions from the plan included weekly review meetings to monitor progress supported by the practice development & quality improvement team, fortnightly meetings with Dundee HSCP and weekly problem assessment groups with a focus on staffing and their wellbeing. These meetings were supported by human resources and staff side representatives.

Use of mental health and incapacity legislation

On the day of our visit, a number of those in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in good order and corresponded to the medication being prescribed, except for one individual. We raised this with the RMO and members of the clinical team on the day of the visit, and were told this would be rectified.

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 (AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We reviewed the documentation of the nine individuals who were subject to the AWI Act. We found only four section 47 certificates were available, and there were no treatment plans were attached. We discussed this with managers and highlighted the necessity of this documentation to ensure compliance with the AWI Act.

Recommendation 5:
Managers should ensure that s47 certificates and associated treatment plans are completed where required and that an audit is in place to monitor compliance.

Rights and restrictions

During our visit, the door to the ward was locked. There was a locked door policy in place which was reviewed daily. Individuals who had been admitted informally were advised at the time of their admission of their right to leave the ward.

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. Where an individual is a specified person in relation to this, and where restrictions are introduced, it is important that the principle of least restriction is applied. When reviewing specified person restrictions under the Mental Health Act, we found the relevant forms were not available in the ward, nor in the clinical record and these had not been sent to the Commission. There also appeared to be confusion regarding whether certain individuals were subject to these restrictions or not.

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

Recommendation 6:
Managers should ensure all specified person restrictions are correctly authorised and that the required notification is sent to the Commission.

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 told that although there were staff drives to complete advance statements, this had been met with reduced engagement by the individuals on the ward. Despite this, we were pleased to hear that the LDAU staff continued to highlight the benefits of advance statements and have included social work, advocacy, and carers to encourage individuals to complete these during the admission process, ongoing care and treatment or at discharge.

The Commission has developed 'Rights in Mind'. This pathway is designed to help staff in mental health services ensure that individuals 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 were told by individuals and relatives that there was a lack of regular, structured, and meaningful activities taking place in the LDAU. We were informed that an activity worker had recently been appointed and that a timetable of activities remained in development. In addition to this role, we were informed that occupational therapists, a music therapist and physiotherapist provided both individual and group interventions for individuals to participate in. We were informed that activities that took place regularly, including cooking groups, escorted walks in and around the grounds of the unit, gym sessions, singing groups and use

of iPads for general interest and educational purposes. We found minimal recording of activities taking place in the care records and would have expected to see these activities recorded in the care records and a note made of whether individuals were offered and accepted or declined to participate.

Recommendation 7:
Managers should ensure that activities which are offered or participated in are documented in care records, including a record of engagement and any benefit from participation.

The physical environment

On the day of our visit, all 10 beds in the LDAU were being used. There is an eleventh additional 'surge' bed, which the LDAU had in use until late August 2023. Surge beds were previously utilised for admissions when no other bed was immediately available. We were told it is likely that in having this additional bed in use during 2023 contributed to the LDAU's high level of acuity. Due to the increased acuity, nurse staffing levels had been increased and continually monitored at the twice daily safety, capacity and flow huddles.

We heard that there were plans to address some areas of the LDAU that were in need of repair and upgrading. Recently, repairs were completed to a communal bathroom and a bedroom area. During our visit, we found space available to provide opportunity for therapeutic activities to take place, however, we found were lacking in purpose. We heard that there were proposals to improve these areas and enable the delivery of therapeutic activities. However, this remains at consultation stage and the budget has not been finalised. Areas of potential development included a relaxation room and an activity room. We noted that one room was particularly unkempt, with food and drink splashed up the wall and on the ceiling. Although we were told plans were in place for a wipe wall surface to be fitted in this room, we were disappointed to find this as it was a space that was accessed regularly by one individual. This was raised with senior managers, and we were given assurance that this room would be made habitable, while awaiting the wipe wall surface area to be fitted.

Recommendation 8:
Managers should give consideration and progress plans for surplus areas in the LDAU to be developed into opportunities for increased therapeutic activities to take place.

Recommendation 9:
Managers should ensure individuals bedrooms are regularly cleaned and maintained to an acceptable standard.

Summary of recommendations

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Recommendation 2:
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Managers should ensure individuals bedrooms are regularly cleaned and maintained to an acceptable standard.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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