Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 1, Carseview Centre, 4 Tom MacDonald Avenue, Dundee, DD2 1NH

Date of visit: 6 November 2023

Where we visited

Ward 1 is a 22-bedded, mixed-sex acute admissions ward in the Carseview Centre. It primarily offers admission for those in the Dundee West area in NHS Tayside.

We last visited this service in November 2021and made recommendations regarding the need for dedicated clinical psychology input, the provision of an activity support worker and the use of 'surge beds'.

On the day of our visit, we wanted to follow up on the previous recommendations and speak with individuals, staff and any relatives/carers who wished to meet with us.

Who we met with

We met with 16 individuals in person and reviewed seven case records. There were no relatives or carers who requested to meet with us.

We spoke with the senior nurse, senior charge nurse, the charge nurse, staff nurses, the activity worker and the chaplain.

Commission visitors

Gordon McNelis, nursing officer

Lesley Paterson, senior manager (East Team)

Tracey Ferguson, social work officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit, we were pleased to find so many individuals who were willing to discuss their experience of their care and treatment in Ward 1. We received positive feedback from individuals who told us that they thought staff were “nice people”, “approachable”, “supportive during recovery” and they were “grateful for reassurance they provide”.

We also heard some comments about the strong smell of cannabis that was present on the ward in the evenings, which many individuals found unpleasant. We raised this with senior managers on the day and were told that they are aware of this issue and were looking at ways to prohibit individuals from using drugs on and around the wards. This has included liaison with other wards, Police Scotland and engaging with individuals to promote the policy on the management of substance misuse on NHS Tayside premises.

Recommendation 1:
Senior managers should continue to explore ways to address the cannabis use in the hospital grounds to ensure a safe and pleasant environment for individuals in the ward.

During our visit, we were told that two individuals’ discharges had been delayed for an extended period of time. Delayed discharge means that an individual remains in hospital despite being clinically fit for discharge. Whilst the Commission acknowledges that some issues remain out of the control of health authorities responsible for the care of individuals, discharge planning should begin on admission. Delayed discharges impact negatively on both individuals that are delayed, as well as on those individuals who require admission to these specialist areas but are unable to be admitted due to the lack of beds.

Care plans

Individual care records and care plans were accessed via EMIS, the electronic record system. We saw examples of care plans that were person-centred, descriptive of individual needs and subsequent interventions, and found these linked with the information that was gathered from admission.

We were pleased to find the content of care plans gave the reader a good account of each individual’s current and historical needs, which was especially helpful for staff who may not be familiar with an individual, or aware of their presentation or circumstances. We found the care plans evidenced individual involvement, however, this was not documented in continuation notes. We would like to have seen discussions about individual involvement and participation recorded in their notes and documented as a one-to-one meeting.

Care plans were regularly reviewed, and we were told five care plans were audited by one of the senior nurses from the ward (senior charge nurse or charge nurse) on a monthly basis. Feedback on these audits was then shared by charge nurses to the named nurse groups. We found the physical health needs of individuals were assessed during the admission stage, reflected in care plans, and newly identified issues were discussed and addressed at the weekly MDT meeting. There had been a focus placed on up-skilling nursing staff to increase their knowledge and to provide support around physical health care checks for individuals.

Training had been provided with a view to building staff's confidence to carry out physical health check procedures, such as electrocardiogram's (ECGs) and venepuncture.

Multidisciplinary team (MDT)

The MDT involved in Ward 1 had a wide range of professional input. The unit had a multidisciplinary team (MDT) consisting of nursing staff, psychiatrists, occupational therapist (OT), activity workers, pharmacist, physiotherapist and a chaplain. On our last visit to Ward 1, we recommended the ward have input from a dedicated activity support worker and we were pleased to hear action was taken to secure this post.

An MDT meeting takes place weekly and from reviewing the care records, we were able to see evidence of individuals and their relatives attending and being involved in these weekly meetings. Where individuals did not attend, we noted that pre-prepared nursing feedback, gathered from one-to-one meetings with individuals, was provided.

We saw good examples of updates and continuations of previously discussed issues, with a common theme that focused on the individual pathway to progress and discharge. There was a new discharge coordinator post in place, which we were told had helped to make the individuals progress towards discharge smoother. Staff told us this approach had contributed to several improvements, including helping to reduce delayed discharges on Ward 1.

A meeting that adopted a service-wide supported approach to discharge planning took place on a weekly basis, and included input from Dundee, Angus and Perth & Kinross Health and Social Care Partnerships (HSCPs) to identify community support that was presented at pre-discharge meetings. We were told this 'test of change' was being carried out across Carseview.

On the day of our visit, we wanted to follow up on the previous recommendation that input from clinical psychology should be available to support staff to develop and deliver psychological therapies and intervention. We were told these posts had been advertised on a few occasions but at time of writing this report, these posts were not filled, and readvertising continued.

Despite this, we were pleased to hear of alternative approaches to deliver the actions of this recommendation with community psychology teams able to provide in-reach services to the ward, however, we heard this arrangement has not been formalised and referrals were rarely made.

Care records

During our review of care records, we found continuation notes were descriptive and linked to care plans. We also reviewed risk assessments and felt the addition of a psychological formulation to address individuals' complex needs would be beneficial. We acknowledge the attempts this far to recruit a psychologist, however, we feel the need for clinical psychology input to support the development of psychological therapies, and interventions across staff and individual groups, is an area that should continue to be a focus and perhaps a more formal arrangement for psychology provision from other areas could be put in place, whilst vacancies remain.

Recommendation 2:
Senior managers should ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and individual groups.

Use of mental health and incapacity legislation

All documentation relating to the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) and the Adults with Incapacity (Scotland) Act 2000 (the AWI Act), including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date.

On the day of our visit, 11 of the 22 individuals in the ward were detained under the Mental Health Act. The individuals we met with during our visit had a good understanding of their detained status where they were subject to detention.

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 place where required, and mostly corresponded to the medication being prescribed. We found that all T3s had been completed by the responsible medical officer (RMO) to record non-consent, however one T2 certificate was completed one month later than when it was required and contained as required intramuscular (IM) medication. The Commission's views is that, T2 forms should not routinely include as required medication to be administered intramuscularly (IM) for agitation. Our view is that a patient is very unlikely to be consenting to IM medication for agitation at the time this is felt to be urgently necessary, thus negating the consent they may have given at the time of the T2 completion.

Recommendation 3:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular auditing compliance with this should be put in place.

Rights and restrictions

A locked door policy remained in place at Ward 1, to provide a safe environment and support the personal safety of the individuals. Although we felt this was proportionate for a percentage of those who were detained in Ward 1, the rights of individuals who are admitted to the ward informally and who do not need the door locked must equally be fully considered. There should be a written information and instruction, if necessary, on how to come and go from the ward. A protocol or policy on the locked door requirements needs to be clearly stated at admission and available to staff and visitors. This should include information on how the individual can come and go freely. It would be good practice and beneficial for this discussion to be recorded and evidenced in the individual's care records. We were pleased to hear the locked door protocol was reviewed daily, communicated at shift handovers and also recorded on nursing office whiteboard.

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 none of the individuals in the ward had an advance statement, despite there being a good level of promotion and encouragement to complete these. Sometimes an individual's mental state had deteriorated to a point where they would not be able to complete an advance statement at that time however, we were pleased to hear that Ward 1 staff continued to highlight the benefits of these, when mental health symptoms stabilise and when individuals are preparing for discharge.

We were told that Ward 1 had strong links with DIAS (Dundee Independent Advocacy Service). Staff felt links had improved with advocacy which had resulted in positive relationships being established. Individuals could self-refer, or staff could request this additional support for individuals.

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 pleased to hear of a newly appointed activity support worker, designated for Ward 1 and also of the positive impact their structured activities had with the individuals on the ward. A planned timetable of activities was developed, following suggestions and feedback gathered from the ward weekly community meeting.

Activities that took place included yoga sessions, creative writing classes and the opportunity for individuals to participate in both ward-based, and external sessions that focussed on well-being and physical health. In addition to this, input from occupational therapy focused on functional needs assessment to identify the level of support required for activities of daily living.

We had positive feedback from the individuals who participated in these activities, but despite this valuable resource providing beneficial input to the ward and individuals, we found minimal accounts of these activities documented in the care records. We felt the beneficial impact of purpose and routine was essential in providing individuals with not only support and structure, but also in enhancing their quality of life. Therefore, we would like to have seen a record of what activities an individual had participated in, whether an individual declined an activity and what the benefit of participation had been. We look forward to this being better evidenced on our next visit.

The physical environment

On the day of our visit, the ward was at full capacity, with all 22 beds occupied. When individuals were admitted and there was no bed immediately available for them, they could be accommodated in a 'surge bed'. A surge bed could be utilised for an emergency admission, however this bed is accommodated in a room which is not a designated bedroom, so has no

en-suite or hand washing facilities and does not have the same ligature reduction features as the other bedrooms. We have asked that the policy for the use of these beds is kept under review and that information regarding the frequency of use of surge beds be sent to the Commission.

Ward 1 had a shortage of space to accommodate several fundamental activities that should be available for individuals, and which would contribute towards their wellbeing. On the ward we observed a lack of available areas/rooms for activities to take place, for individuals to meet with visitors / relatives in privacy and also a significant lack of storage. We noted one room that was previously used for storage or activities had been converted into the "surge room" which we considered should have remained as an integral part of providing individuals with opportunities to engage in essential occupational activities, structure, and routine.

Recommendation 4:
Managers should consider the use of space in Ward 1 and whether provision can be made for additional therapeutic space which would support and enhance individual wellbeing.

Summary of recommendations

Recommendation 1:
Senior managers should continue to explore ways to address the cannabis use in the hospital grounds to ensure a safe and pleasant environment for individuals in the ward.

Recommendation 2:
Senior managers should ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and individual groups.

Recommendation 3:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular auditing compliance with this should be put in place.

Recommendation 4:
Managers should consider the use of space in Ward 1 and explore whether provision can be made for additional therapeutic space which would support and enhance individual wellbeing.

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.

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