Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 2, Carseview Centre, 4 Tom Macdonald Avenue, Dundee, DD2 1NH

Date of visit: 29 November 2023

Where we visited

Ward 2 is a 22-bedded, mixed-sex general adult psychiatric acute admission ward in the Carseview Centre. It primarily provides admission beds for the Dundee East area across NHS Tayside.

We last visited this ward in November 2021 and made five recommendations regarding psychology input to the ward, improved referral pathway, availability of advocacy services, review of surge bed use, and ensuring confidentiality of individuals' information.

We were told on the day of our current visit that recruitment for a psychologist post was ongoing however, there was input from community psychology services to deliver training to ward staff in the meantime. Advocacy services were now available in the ward for face-to-face appointments. There was ongoing review and monitoring of surge bed use at the inpatient mental health care and professional governance group. The whiteboard with individuals' information had been relocated to a less visible area. In addition to this, information on the whiteboard had been anonymised.

Who we met with

We met with nine individuals and one relative and reviewed seven case records. We spoke with the lead nurse, senior nurse, senior charge nurse, and charge nurse.

Commission visitors

Gordon McNelis, nursing officer

Tracey Ferguson, social work officer

Anne Buchannan, nursing officer

What people told us and what we found

Care, treatment, support and participation

We wanted to meet as many individuals as possible and those we met told us staff "really cared", "were motivated", "energetic", and "made a massive difference". Individuals shared experiences with us where staff had offered them support and reassurance following incidents that had taken place on the ward. We were told this approach made them feel safe and contributed to the ward having "an air of calmness". Individuals knew who their named nurses were and felt comfortable approaching them to discuss issues they had.

Relatives told us they "felt involved" and that their views on their family members' care, treatment, and progress were taken into account.

Care plans

Care plans were accessible via EMIS, an electronic recording system. We found these to be person-centred, thorough, and provided the individual with a good description and impression of historical and current circumstances and presentation. We saw good examples describing risks and triggers that affect each individual's mental health and clear guidance and self-help measures that had been put in place to support each individual's needs during this time. We also saw care plans that focused on preparing individuals for discharge. Despite the positive content, the layout of care plans appeared disorganised. This was raised with managers at our end of visit meeting.

We received mixed feedback regarding individuals' involvement and contribution to care plans. Although it was clear each individual's view had been sought, we were unable to find where these discussions were documented. We would encourage this conversation to be evidenced as a one-to-one encounter, including whether the individual participated or declined to be involved, in the appropriate sections of care plan review and continuation notes also.

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

Delayed discharge

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 who require admission to these specialist areas but are unable to be admitted due to the lack of beds. Ward 2's response to this had been for the discharge planning process to be taken into consideration at time of admission and delayed discharge cases to be discussed at weekly rapid rundown meetings to improve referral pathway. These meetings included attendance by community mental health teams (CMHTs) which provided them with awareness of these individuals who were preparing for discharge into the community setting.

In addition to this, there is now a designated discharge coordinator in place to identify potential barriers to individuals' progress into the community. Since they were recruited to

post in July 2023, we were told of improvements, with delayed discharges reportedly halved over the four months prior to our visit.

Multidisciplinary team (MDT)

The unit had a multidisciplinary team (MDT) consisting of nursing staff, consultant psychiatrists, activity support worker, and occupational therapy staff. There were staffing deficits with registered mental health nurses (RMNs) and health care support workers (HCSWs), with these posts to be advertised soon.

We heard that MDT meetings took place weekly. Although individuals told us their views were gathered prior to MDT meetings, we had some difficulty finding MDT documents to review. We discussed our observations with managers on the day of our visit and will follow this up during future visits.

Recommendation 1:
Managers should ensure that MDT meeting records clearly record attendance, discussion and outcomes of the MDT meeting and individual participation in these meetings is evidenced.

A new MDT programme had been implemented for individuals who were admitted with a mental health crisis, trauma, or an emotionally unstable personality disorder (EUPD) diagnosis, where hospital was viewed as a benefit for a short, structured period of time. When it was identified that the individual would be taking part in this two-week programme, their admission was generally nurse-led with a focus on nursing skills and interventions for recovery, and value placed on purpose and structure. There was an onus on the individual being an active participant in their admission and therefore refraining from escalating self-harm, anti-social behaviours, drugs, or alcohol use. Staff told us this approach received positive feedback from the group of individuals involved and gave them a clearer understanding of how long their stay in hospital may be.

From our last visit we recommended that there should be input from dedicated clinical psychology to enhance the care and treatment. At the time of our visit, despite finances being secured and two rounds of advertisements, this post had not been recruited to. Management recognised the need for psychology input to support the development of valuable psychological interventions and formulation. In response to this, community psychology services had provided in-reach to the ward and nursing staff had participated in safety and stabilisation training while attempts to recruit remain ongoing. We hope these attempts are successful and this post will be filled soon.

Recommendation 2:
Managers should continue with their attempts to ensure there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and patient groups.

Care records

We were pleased to find care records contained relevant information and were in good order.

In addition to electronic records, we also found hard copies. We understand the importance of keeping some records in paper format however, we would prefer if this was kept to a

minimum and only for key, relevant information that may be required in an urgent situation, should there be no access to online information. We would view duplication of all clinical records to be a potential risk that information may be inaccurate or difficult to maintain, and this should be avoided.

Recommendation 3:
Managers should review the storage of care records to avoid unnecessary duplication and ensure all information is current and regularly maintained.

Use of mental health and incapacity legislation

On the day of our visit, 14 of the 22 patients in Ward 2 were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Seven were subject to a compulsory treatment order (CTO) and seven to a short term detention order (STDC). A review of individuals' care records showed that all detention paperwork was in good order.

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. During our review, we found one error on a T3 form, which was discussed with the team.

Rights and restrictions

A locked door policy remained in place on Ward 2 to provide a safe environment and to support the personal safety of the individuals. Although we felt this was proportionate for most of those who were detained, the rights of individuals who were admitted to the ward informally and did not require a locked door must equally be fully considered, so that they can have free access to the outside world. They should have written information and instruction, if necessary, on how to come and go from the care setting. Protocol on door locking 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 individuals' care records. We were pleased to hear the locked door protocol was reviewed daily however, we were unable to find evidence in care records of the locked door protocol being explained to individuals in Ward 2, and the options they had regarding leaving the ward.

Recommendation 4:
Managers should ensure that the 'NHS Tayside Locked Door in Mental Health Settings' policy is explained to individuals on the ward and those who are informally admitted are advised of the procedure for accessing and leaving the ward when the door is locked.

During our previous visit to Ward 2, the Commission made a recommendation for managers to liaise with advocacy services to progress towards face-to-face access in the ward. We were pleased to hear this had resumed and that advocacy had a visible presence on the ward.

The term 'advance statement' refers to written statements made under sections 274 and s276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting

advance statements. We were told no individuals in Ward 2 had an advance statement. Although staff told us the benefits of having an advance statement was discussed with the individuals on the ward, this had been met with limited engagement and individuals had chosen not to complete them. Ward 2 staff will continue to have further conversations with individuals about advanced statements and recommend these be completed at discharge planning stage.

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

We were pleased to hear positive feedback from patients, relatives, and staff about Ward 2's activity support worker. We were told the standard and variety of activity provided contributed towards the individuals' quality of life on the ward. This positive impact seemed evident from speaking with the staff member and discussing their role and responsibilities.

There was a planned timetable of activity for the week ahead which demonstrated a positive level of engagement and participation by individuals. The timetable was flexible to allow for preferences of the changing individual group and to also take into consideration whether there was a demand for group or one-to-one activities.

The physical environment

On the day of our visit, the ward was at full capacity, with 22 beds occupied and three individuals on overnight pass. When individuals were admitted and there was no bed immediately available for them, they could be accommodated in a 'surge bed'. Ward 2 staff told us that although the surge bed was not used as much, it remained available for use. In response to our previous visit and recommendation, we were pleased to see the policy for surge beds continued to be kept under review, including through daily huddles and service governance meetings.

Ward 2 was a busy ward and our observation of the lack of available space contributed to the sense that the ward was a cramped environment. We felt additional room, to facilitate activities and therapeutic work, would be beneficial not only to the individuals, but also the ward staff. Therefore, we would ask that managers consider the use of available space in Ward 2 and whether this could be adapted to facilitate a welcoming space for visitors or family room or an area that facilitates therapeutic activities.

A common complaint raised by individuals was about the ward's shower system and the poor water pressure during showering. Ward staff were aware of this issue and informed us the water system was overworked, due to the location of the ward, which was external to the main Carseview Centre building. Although managers had looked at providing a solution, we were told the only way to solve this would be to move the ward to an alternate site.

The facilities management provider maintains the garden area and although this is an accessible outdoor space that should be aesthetically pleasing for individuals in Ward 2, we noted cigarette ends and litter made the area unpleasant looking. We raised this with managers at the end of the day and would like to see this area presented in what should be a

beneficial area for all to experience. We were told of plans by a local charity to donate funds to Ward 2. Managers planned to use these funds to improve the garden area and install an outdoor gym. We look forward to seeing this on our next visit.

Ward 2 is in phase two of the NHS Tayside anti-ligature work that included new anti-ligature door top alarms, towel holders, and soap dispensers being fitted, as well as an upgrade to the ward alarm system. As with all new products being fitted, we would expect those to be risk assessed and suitably meet the essential standards of the NHS Tayside anti-ligature work.

In response to our previous visit and recommendations, we were pleased to see the window section of the nursing office door covered up with frosted film to hide confidential information from those outside the nursing office. In addition to this, the white board had been moved from the original position and individuals' information anonymised.

Recommendation 5:
Managers should consider the use of space in Ward 2 and whether provision can be made for additional therapeutic space which would support and enhance individuals' wellbeing.

Summary of recommendations

Recommendation 1:
Managers should ensure that MDT meeting records clearly record attendance, discussion and outcomes of the MDT meeting and individual participation in these meetings is evidenced.

Recommendation 2:
Managers should continue with their attempts to ensure there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and patient groups.

Recommendation 3:
Managers should review the storage of care records to avoid unnecessary duplication and ensure all information is current and regularly maintained.

Recommendation 4:
Managers should ensure that the 'NHS Tayside Locked Door in Mental Health Settings' policy is explained to individuals on the ward and those who are informally admitted are advised of the procedure for accessing and leaving the ward when the door is locked.

Recommendation 5:
Managers should consider the use of space in Ward 2 and whether provision can be made for additional therapeutic space which would support and enhance individuals' wellbeing.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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