Mental Welfare Commission for Scotland

Report on unannounced visit to: Mulberry Ward, Carseview Centre, 4 Tom Macdonald Avenue, Dundee, DD2 1NH

Date of visit: 12 March 2024

Where we visited

Mulberry Ward is a 20-bedded, mixed-sex adult acute psychiatric admission ward, based in the Carseview Centre. Mulberry Ward primarily provides care for individuals from the Angus area of Tayside.

On the day of our visit there were 19 people on the ward and one vacant bed.

We last visited this service in December 2022 on an announced visit and made recommendations related to individuals' involvement in their care plans, clinical psychology provision in the ward, the completion of multidisciplinary (MDT) meeting documentation, the authorisation of psychotropic medication, informal individuals being made aware of their rights and improved access to garden areas.

Who we met with

We reviewed the care of seven people, seven whom we met with in person and six who we reviewed the care notes of.

We spoke with the senior charge nurse, charge nurses, and lead nurse.

Commission visitors

Gordon McNelis, nursing officer

Lesley Paterson, senior manager (practitioners)

Tracey Ferguson, social work officer

What people told us and what we found

The individuals we spoke with on the day of our visit made positive comments about staff. We were told they were "good", "supportive", "most of them are approachable" and "I found talking to them had helped". Other comments were "I get on with staff" and that they found one-to-one discussions with staff were "good for explaining medication and symptoms (of mental health)". We were also told of an individual's negative impression of the ward prior to their admission however, they were surprised to find the staff were "very supportive" and allowed them their "own space" during their time as an inpatient. Although some individuals were unhappy about being in the ward, they did mention that they were aware of their rights. We found that a common theme raised with us was around the difficulty in accessing the garden area.

Care, treatment, support and participation

Care records

Information on individual's care and treatment was held electronically on the EMIS system and was easily found. Care plans were holistic, detailed, person-centred, future focused, were regularly reviewed and audited. We found pharmacy input to care plans was robust and linked to community pharmacy.

During our visit, we wanted to follow up on our previous recommendation regarding individual involvement with care plans and whether they received a copy. We were told the ward encouraged individuals and carer/family involvement with care plans, and we were pleased to find evidence of these discussions taking place in care records.

Mulberry Ward, together with the quality improvement team, had put together a new template for nursing staff to use when carrying out one-to-one discussions with individuals. We found evidence of regular one-to-one support being offered to individuals and whether they accepted or declined to participate in these discussions was documented. However, in some cases where one-to-one discussion took place, it seemed these entries mostly contained views from nursing staff, as opposed to recording the individual's views. We would have found it helpful if the views and participation of the individual had been reflected in discussions that took place, including their needs (met and unmet) and aspirations; finding out what people want out of an admission could influence the proposed treatment plan and help recovery.

Multidisciplinary team (MDT)

A range of professionals were involved in the delivery of care and treatment in the ward. This included psychiatry, nursing staff, health care support workers, physiotherapy, occupational therapists (OT), pharmacists, support staff, activity support workers (ASW) and discharge co-ordinators.

We wanted to follow up on our previous recommendation regarding having a clinical psychologist dedicated to the ward and we were told that although a psychologist had not been appointed, the ward had access to psychology input while recruitment drives were ongoing.

MDT meetings were held weekly and were well attended by all MDT members, including the discharge co-ordinator. We were told discharge planning for individuals began from the point

of admission. The ward had discharge support from the Angus discharge hub team who attended MDT meetings, to support discharge for individuals to these areas in a 'more fluid' way.

We found the documents relating to MDT meetings to be in good order and included a clear record of attendance. The MDT meeting template included space for a detailed record of discussions and focused on all aspects of individuals' care and treatment, including future planning. We found evidence of individuals and their relatives being invited, as well as their participation in MDT meetings, and their views discussed and recorded.

Use of mental health and incapacity legislation

On the day of the visit, seven people were subject detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). Some of the individuals we spoke with said they had an understanding of their rights and what it meant to be detained under 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 place where required, and mostly corresponded to the medication being prescribed. During our review, we found one error with a T3 certificate and one on a T2 certificate.

We found intramuscular (IM) "as required" medication prescribed on a T2 form. The Commission is of the view that advance consent of an individual would be invalid if they withdrew this consent later, when the medication was given or if restraint is involved. It is our view that "as required" IM medication should be authorised on a T3 certificate.

We were told that pharmacy staff undertook regular audits to ensure the correct authorisation of psychotropic medication however, we saw no evidence of nursing audits taking place. We discussed the importance of nursing staff ensuring that all psychotropic medication which they administer was legally authorised.

Recommendation 1:
Managers should introduce a robust audit system to ensure that all psychotropic medication prescribed under the Mental Health Act is appropriately and legally authorised.

Rights and restrictions

A locked door policy remained in place at Mulberry Ward to provide a safe environment and support the personal safety of individuals. Although we felt this was proportionate for a percentage of those who were detained, the rights of individuals who were admitted to the ward informally and did not require a door locked 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 ward. Protocol on door locking needs to be clearly stated at admission and available to staff and visitors. It would be good practice and beneficial for this discussion to be recorded and evidenced in the individuals' care records.

Nursing staff on the ward told us the locked door protocol was reviewed every three months. We felt this lack of frequent review could potentially cause an individual to be subjected to unnecessary and excessive restrictions and that review of the locked door protocol should take place more frequently to avoid an individual's liberty to be unlawfully restricted. Managers have since told us that the locked door policy should be reviewed daily and advised that the protocol is currently under review following previous Commission feedback.

Recommendation 2:
Managers should ensure the need for the ward door being locked is reviewed daily and that all individuals who are admitted to the ward informally are aware of their rights around this.

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 a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we noted a lack of reasoned opinions, which should provide detail on the rationale for why the individuals were subject to specified person restrictions. We would have expected to find detailed recorded reasoned opinions, which supported the restrictions imposed on an individual to be held in the care records and notification of specified person restrictions to be sent to the Commission.

Our specified persons good practice guidance is available on our website.

Recommendation 3:
Managers should review current processes in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

Recommendation 4:
Managers should consider MDT training in the application and use of specified persons to ensure all staff are cognisant with all aspects of this legislation.

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 is written when a person has capacity to make decisions on the treatments they want or do not want. Advance statements are an important contributor to the collaboration between the clinical team and the patient in promoting a therapeutic relationship and aiding recovery. Health boards have a responsibility for promoting advance statements.

We were unable to locate any advance statements in the records we reviewed on Mulberry Ward and would like to have seen increased prompting and promotion of them. This should be facilitated by encouragement by an individual's named nurse, regular discussions taking place at e.g. MDT meetings, be part of discharge planning or as part of regular care programme approach (CPA) meetings.

Recommendation 5:
Managers should ensure the promotion of advance statements, to provide an opportunity for patients to make decisions and choices about their future care and treatment.

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.

Activity and occupation

Mulberry Ward had input from their designated ASW over a seven-day period, and from OT and support staff who also covered other wards in the Carseview Centre.

There was an informative timetable with a broad range of options of therapeutic activities, such as yoga, art groups, baking, quizzes, board games, therapet visits, relaxation groups, and access to a masseuse for both individuals and members of staff. There was also focus on improving physical health, with access to the gym, playing football and physiotherapy.

We heard complimentary comments from individuals about the variety and benefits of activities on offer however, we had difficulty finding activity participation recorded on EMIS. We would like to have seen a record of the activities that took place documented in the continuation notes, including information on whether the individuals accepted or declined to participate. OT assessments were thorough, person-centred, and gave a detailed description and rationale for the activities offered.

The physical environment

The layout of the ward was split into separate male and female sides with ensuite facilities in each individual rooms. The ward had a sitting room, a dining area, and an art room. A common theme amongst the individuals we spoke with was the difficulty they had accessing the garden area. Due to the location of the ward, there was no direct access, instead individuals were escorted by members of staff through the emergency exit to an area known as “the cage”, a locked off area adjacent to the garden. We were told reduced staffing numbers could affect the frequency of when individuals had access to the garden.

We wanted to follow up on our previous recommendation regarding improved access to the garden. We were told the redevelopment of an area next to the existing garden was planned to be made into a therapeutic area, dedicated to individuals from Mulberry Ward. We look forward to seeing this at our next visit.

Summary of recommendations

Recommendation 1:
Managers should introduce a robust audit system to ensure that all psychotropic medication prescribed under the Mental Health Act is appropriately and legally authorised.

Recommendation 2:
Managers should ensure the need for the ward door being locked is reviewed daily and that all individuals who are admitted to the ward informally are aware of their rights around this.

Recommendation 3:
Managers should review current processes in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

Recommendation 4:
Managers should consider MDT training in the application and use of specified persons to ensure all staff are cognisant with all aspects of this legislation.

Recommendation 5:
Managers should ensure the promotion of advance statements, to provide an opportunity for patients to make decisions and choices about their future care and treatment.

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.

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