mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on unannounced visit to:
Strathmartine Centre, Flats 1 ,2, and 3, Craigmill Lodge, Craigmill Road, Dundee, DD3 0PG

Date of visit: 29 May 2024

Where we visited

Strathmartine Centre has learning disability (LD), inpatient units known as flats 1 ,2 and 3. Flat 1 was a low-secure environment for male patients with a diagnosis of a learning disability and a history of offending behaviour. Flat 2 was separated into east and west wings. The east wing had two individuals housed there and the west wing had one individual housed there and was under refurbishment, with plans to split this section into two separate living areas for two individuals. Flat 3 was the behavioural support and intervention unit (BSIU), which had an east and west wing, housing one individual in each wing. Flat 3 provided care and treatment to male and female patients with a diagnosis of a learning disability who could experience stressed and distressed behaviours.

The visit also included the Strathmartine Centre therapeutic area, Craigmill Skill Centre, and to Craigowl Ward, where an enhanced care area had been provided for an individual. Due to the nature of environmental work required, this temporary arrangement had been in place for some time.

We last visited this service in April 2023 on an announced visit and made nine recommendations regarding the development of easy read care plans, patient participation to be documented, MDT meetings to be fully recorded, case notes to include a copy of welfare proxy powers, restrictions to be legally authorised, the pinpoint alarm system, the need for a long term seclusion policy to be developed, clear goals to be included in care plans and for senior managers to decide whether the current estate would be upgraded or an alternative be sourced.

The service response to these recommendations was that easy read care plans were being developed in association with quality improvement and practice development team (QIPD). QIPD team training was delivered to ensure the level of patient participation in care plans were documented appropriately. Alterations were made to the MDT template, including a section indicating whether individuals participated or not. We were advised that a copy of the welfare proxy document showing proxy powers was held in case notes and all specified persons restrictions were legally authorised and regularly reviewed. The pinpoint alarm system was upgraded and working fully, and the seclusion policy review was in progress and would include include CCTV use. Training was to be delivered to identify achievable goals and actions for individuals in seclusion, urgent repair requests were escalated to the estates department, but the long-term decision on the future of the Strathmartine estate was undecided.

Who we met with

We met with one individual in person and reviewed five sets of care records. We also spoke with one relative prior to our visit.

We spoke with the charge nurse, clinical director, consultant psychiatrist and senior nurse. We also met with advocacy.

Commission visitors

Gordon McNelis, nursing officer

Alyson Paterson, social work officer

Sheena Jones, consultant psychiatrist

Matthew Beattie, ST6 (trainee doctor)

What people told us and what we found

There was limited opportunity to engage with the individuals as a result of their learning disability however, feedback from staff provided us with helpful historical and current information about the individuals in the service. There was one individual who was happy to meet with us in the presence of a nurse. They spoke enthusiastically and positively about the daily activities they engaged in and had praise for the “excellent facilities on site”. They also mentioned “I like the quiet and peaceful green surroundings” and that “staff are all very pleasant”.

The relative we spoke with previously contacted the Commission to express their concerns with their family member’s living environment. Despite these complaints, they had praise for staff and described them as “brilliant”.

Care, treatment, support and participation

Care records

Information on each individual’s care and treatment was held electronically on the EMIS system. We found care records stored electronically and also in paper format. There are potential risks in having two systems to record information and we would advise that all information should be held electronically, as is the case in other services in NHS Tayside.

We found nursing continuation notes were descriptive however, we had difficulty finding when the therapeutic interventions that were recorded had taken place. We would expect that all therapeutic interventions to be documented.

We found nursing care plans person-centred, comprehensive, and detailed. One care plan was 117 pages long and although this contained a robust level of information, it was difficult to navigate as it contained extensive historical information and updates. We feel care plans of this length would benefit from a summative evaluation. We found restrictive interventions, including seclusion were covered in care plans with reference made to Commission’s *Use of Seclusion good practice guidance*.

The care plans were relevant to the care being provided and included regular recording of enhanced observations and monitoring of individuals during that time.

We found in-depth positive behaviour support (PBS) plans on file that included useful historical information, which explored the individuals’ behaviours, triggers and presentations. The PBS plans also provided good information on the individuals’ needs and guidance on how to support and interact with each individual. This information gave the reader a good understanding of the individual and would be beneficial to those staff who may have been unaware of their typical presentation. The PBS plan also contained a traffic light risk assessment/management tool.

Multidisciplinary team (MDT)
There are a range of professionals involved in the provision of care and treatment in the units. This includes nursing staff, both registered mental health nurses (RMNs) and learning disability (LD) nurses, consultant psychiatrists, psychology, pharmacy, occupational therapy (OT) and an activity support worker. There was external support from a GP for physical health input.

We found the staff group in Strathmartine Centre dedicated and knowledgeable about the individuals in their care and the staff team appeared to be fully committed to contributing to the wellbeing and improving the quality of life to those in their care. One staff member we spoke with mentioned Strathmartine Centre staff were “a great team to work with”. We were told of plans to increase the nursing workforce to include more equity in the number of RMNs and LD nurses, and for a learning disability training package to be provided for RMNs working in LD services.

We heard that full MDT meetings took place monthly. We wanted to follow up on our previous recommendation regarding MDT meeting documentation to include whether patients or their relatives did or did not attend. We found a comprehensive MDT meeting proforma on file, but unfortunately it was rarely fully completed, with information including meeting dates and legal status missing and patient/guardian input/feedback all incomplete. We also found MDT meetings records were brief and did not outline the discussions that took place during the meeting.

Recommendation 1:
Managers should ensure that MDT meetings are fully recorded, that all sections of the MDT meeting proforma is completed and that individual and/or carer involvement is promoted, where appropriate.

Five individuals that we planned to meet with during our visit were regarded as delayed discharge. This means that despite them being clinically fit for discharge, they remained in hospital. We were told accommodation had recently been identified for them to be discharged to however, this process would be slow to progress, as these places were still to be refurbished and adapted to each individual’s specific needs and made secure for entry. We met with one individual whose discharge was delayed in the last year but had only recently been allocated a social worker. On the day of the visit, we were told that Dundee Health and Social Care Partnership (HSCP) appeared to have limited input with collaborative discharge planning. However, were advised following the visit that this may be a perception of individuals on the day but was not reflective of the work that was happening with the service and Dundee HSCP.

Recommendation 2:
Managers should monitor and record discharge planning activity for patients whose discharge has been delayed, to ensure this remains focussed and within agreed timescales.

Recommendation 3:
Managers should ensure a service-wide supported approach to discharge planning, which includes the community learning disability service and health and social care partnership, with the discharge planning process being considered at the point of admission. Delayed discharge cases should be discussed during MDT meetings to improve the onward referral pathway.

Recommendation 4:
Managers should consider discharge co-ordinator involvement to identify potential barriers and suitability of accommodation for individuals discharge into the community.

Use of mental health and incapacity legislation

On the day of the visit, all individuals in the unit 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 those individuals who are detained, who are either capable or incapable of consenting to specific treatments. On reviewing the electronic and paper files, we found the electronic medications kardex stored on the hospital electronic prescribing and medicines administration (HePMA) online system. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

For those people that were subject to Adults with Incapacity (Scotland) Act, 2000 (AWI Act) legislation, we found all documentation relating to this, including certificates around capacity to consent to treatment, were on file and in date. We also found a communication sheet for contact with the legal guardian which showed a plan for weekly contact. It was positive to see this however, nursing notes did not reflect this contact taking place. We would expect to see contact with the guardian recorded in continuation notes.

Rights and restrictions

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

Advocacy services were based on the Strathmartine site, and we were told they had a regular presence on the site which promoted easy access for individuals.

Some patients were nursed using CCTV with monitors based in nursing office adjacent to the reception area of each flat. We saw individuals cared for via a continuous seclusion care plan. However, following our conversations with staff, reading case notes and understanding the individuals' routine and structure, we felt the description of continuous seclusion would not be the proper language to use in these cases. We found individuals were not constantly in seclusion, as staff would often engage with them face-to-face and also escort them on community outings. We felt it should be clearly documented when seclusion was stopping and starting with a view to build on this as an exit strategy from seclusion.

We were pleased to find that where long term seclusion was in use, external reviews as per the NHS Tayside seclusion policy, were taking place with some individuals who were restricted in this way. However, it was not clear if all individuals subject to seclusion had been externally reviewed. We consider that an external review of individuals, subject to this level of seclusion, should be undertaken to identify the impact on them, and provide a review of any therapeutic benefit of this. A review would also ensure that consideration of what the longer-term plans were required, including identifying positive risk-taking strategies, in order for individuals to move out of long-term seclusion.

Following on from our visit, we discussed the seclusion status of individuals with Strathmartine staff. We were told that a review of NHS Tayside's seclusion policy was ongoing and had been for some time. As identified during our last visit, the seclusion policy in place did not include CCTV monitoring, and this must be considered in the seclusion policy review.

Recommendation 5:
Managers should ensure the correct terminology is used in line with the Commission's *Use of seclusion good practice guide*.

Recommendation 6:
Managers should ensure regular external reviews of those subject to seclusion take place.

Recommendation 7:
Managers must progress the review of NHS Tayside's seclusion policy, to ensure it supports the restrictive practices which are currently in place, including how and when CCTV is used to monitor individuals.

Activity and occupation

During our visit, we found the activities for individuals were determined by the level of assessed risk. However, due to individuals being cared for in seclusion and the risks associated with face-to-face engagement, we found the meaningful activities that were provided were restricted.

Activities that individuals participated in were engaging with jigsaw puzzles, music groups, and going on escorted walks. Hospital transport was available for supported visits to the family home and visits to local resource centres and shops. Due to individual needs and the level of risk, access to the community setting was not suitable for everyone however, for those who were able to travel in transport, we found they were unable to due to the risk assessed specialised harness equipment not being available, despite requests for these.

We were informed of some therapeutic activities that took place; these included breathing exercises, use of sensory equipment including bubbles and water play. We heard about the benefits of sensory equipment however, these did not appear to be readily available for all individuals, with a lack of resources noted that would support this beneficial therapeutic intervention being provided.

Recommendation 8:
Managers should ensure that activities are person-centred and reflect the individual's specific preference and care needs.

Recommendation 9:
Managers should ensure there is availability of equipment to enable meaningful and therapeutic intervention/activity.

The physical environment

On the day of our visit, we particularly wanted to focus on the living space of individuals in Strathmartine flats. This was in response to concerns about the condition of these areas that were brought to our attention from various external sources.

Initial impressions of the reception area in flat 3 were unappealing and unwelcoming to ward visitors and smelled of urine (this smell was noted in other areas across the site). The CCTV monitor screen was visible to passers-by in the reception area. This was in stark contrast to the reception area in flat 1, where the reception area was bright, welcoming, well maintained, had colourful pictures and information, including artwork by individuals on the walls. The nursing station had a curtain over the window that blocked out the CCTV monitor screen, to promote privacy.

We had access to flat 3's east wing, where we observed parts of an individual's living space, which was in a significant state of disrepair and neglect. We noted significant deterioration in the corner of the main living area with large holes in the ceiling/wall and above the window frame. This area had a large section of the paint that had peeled away on the wall, exposing cracked and crumbled plasterwork, dampness and black mould. There was heavy rain at the time of our inspection, and we noted water steadily leaking through the ceiling into the room. This had caused the wooden window frame to rot over a period of time. We were unable to look at the external

part of the roof at this area. The toilet area was also in poor condition and notably unhygienic. There was significant damp and black mould around the toilet that had caused the surrounding areas to deteriorate and fall into disrepair, with paint peeling off and exposing crumbling plasterwork underneath.

Our visit continued to the west wing of flat 3, which is in the process of being refurbished to accommodate two separate living areas. We found the renovation work on this site had not progressed since our last visit to Strathmartine flats in April 2023. We were unable to gain entry to flat 2 west wing however, we were told a wooden windowsill had fallen into disrepair and had rotted, due to regular seepage of urine.

We also had partial access to view a converted living space in the Craigmill Skill centre that was used to temporarily accommodate an individual while waiting on flat 3's refurbishment. This was known as an enhanced care area. We found parts of this non-clinical area had fallen into disrepair with extensive damage noted to the walls surrounding the main entrance. We were told the windows in this area did not open which caused temperatures to rise significantly and we were concerned with reports that this rise in temperature had caused in an infestation of flying ants inside the enhanced care area.

Access to the hospital grounds was available however, this area was unsecure and in response, industrial perimeter fencing was in place to provide an enclosed garden space for the individual. Although external access provided quality of life for the individual who was housed there, the type of fencing in place was unsuitable and not conducive to a therapeutic environment. All other individuals had access to well-maintained secure garden spaces.

We viewed other areas in the Craigmill Skill Centre and in particular, the staff office for the CMHT service. We observed environmental deterioration/damage to the window area, similar to flat 3. We were told that a rodent had at one point fallen through the roof, such was the state of deterioration and disrepair.

These areas in Strathmartine appear to have deteriorated with years of delay and inaction in terms of service redesign and relocation. A lack of investment in repairs to the current building have been significantly detrimental to individuals who are housed in this setting and with staff welfare and morale. The repairs that had been completed were minimal and makeshift and had done little to address the significant state of disrepair which was evident.

Recommendation 10:
Managers should, as a matter of urgency, make a decision regarding the estate and whether the current estate will be significantly upgraded or an alternative more suitable accommodation be sourced.

Recommendation 11:
Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as is practicable.

Recommendation 12:
Managers should, ensure that flat 3 reception area is welcoming and fit for purpose.

Recommendation 13:
Managers should ensure a programme of work, with identified timescales, to address the environmental issues.

Any other comments

Following the Commission's visit to Strathmartine Hospital flats, we felt it necessary to provide feedback to the leadership and senior management team, with a view to highlighting the areas we felt required further discussion, primarily the significant concerns we had in relation to the environment and the impact this could have on the wellbeing and safety of the individuals and staff in the unit.

In addition, we felt it necessary to escalate our concerns and bring our visit findings to the attention of the chief executive for this area. We will continue to follow up this matter as appropriate, however, it is positive to note that the leadership team for the health board and the HSCP have actively responded to the concerns raised by the Commission.

Summary of recommendations

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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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