Mental Welfare Commission for Scotland

Report on unannounced visit to: Carseview Centre, Intensive Psychiatric Care Unit (IPCU), 4 Tom Macdonald Avenue, Dundee, DD2 1NH

Date of visit: 18 March 2024

Where we visited

The IPCU is a 10—bedded, mixed-sex ward based in the Carseview Centre. The unit provides intensive treatment and interventions to adults in the Tayside area.

On the day of our visit, there were 10 people on the ward and no vacant beds.

We last visited this service in December 2021, on an announced visit and made recommendations that positive risk taking should be included in risk management plans, that there is dedicated clinical psychology input into the ward, and an admission policy should be developed with regards to individuals inappropriately placed in IPCU.

The response we received from the service was that positive risk taking would be evidenced more effectively. We were advised that although finance had been secured, two rounds of recruitment for psychologists were unsuccessful, which had prompted alternative psychology in-reach to the IPCU from existing adult services. Lastly, the IPCU admission criteria was being adhered to in multidisciplinary team (MDT) discussion and there was an agreement that the Commission would be informed of admissions of individuals who did not meet this criterion.

Who we met with

We met with, and reviewed the care of four people, three who we met with in person and four who we reviewed the care notes of.

We spoke with the senior charge nurse, the lead nurse, nursing staff, consultant psychiatrists and the clinical director.

Commission visitors

Gordon McNelis, nursing officer

Alyson Paterson, social work officer

What people told us and what we found

The individuals we spoke with on the day of our visit gave positive comments about staff. We were told they were “approachable”, “couldn’t ask for better support”, “brilliant”, “genuine” and “it’s a relief to feel people are working for my benefit”.

We also heard some negative comments where individuals felt “trapped and isolated” and that “the food was bland”.

Care, treatment, support and participation

Care records

Information on care and treatment was held electronically on the EMIS system and was easily found. We found nursing care plans were person-centred, descriptive and gave the reader a good impression and understanding of the individual’s needs, with agreed goals and interventions. We found these linked with admission assessments, historical factors and risk assessments.

We saw documented evidence of staff attempts to include individuals in developing care plans, and whether they participated or not. However, one individual we spoke with told us they hadn’t received a copy of their care plans. This was raised with staff on the day who told us not all individuals will accept their care plans however, these would be offered to the individual again.

We were told care plans were regularly reviewed and audited once per month. We heard that the individual’s named nurse reached out to their carer or relatives within a 72-hour period of their admission and encouraged them to be involved with developing care plans. This was described as an open invite if the individual consented to family members being contacted, and their information being shared.

We were told all staff used the ‘triangle of care’ approach to improve engagement and communication with carers and relatives. The ‘triangle of care’ describes a therapeutic relationship between the individual, staff member and carer/relative that promotes safety, supports communication, and sustains wellbeing.

We were advised that care plans could be adapted to easy read format dependant on the individual’s needs and level of understanding. Speech and language therapy input had used to provide guidance with these, although at the time of our visit, no individuals required this style of care plan.

We found one-to-one discussions between the named nurses and the individual were offered regularly and it was documented whether the person participated or not. The individuals we spoke with were aware of their named nurse and we were told “if I ask for a one-to-one discussion, I’ll get it”.

We wanted to follow up on our previous recommendation regarding the development of risk management plans that would encourage positive risk taking. We were told there was increased awareness of positive risk-taking options and these were discussed at MDT meetings, with a view to any actions taken being evidenced more effectively.

Multidisciplinary team (MDT)
A range of professionals were involved in the provision of care and treatment in the ward. This included psychiatry, nursing staff, health care support workers, occupational therapist (OT), physiotherapist, and an activity support worker (ASW).

We wanted to follow up on our previous recommendation regarding establishing dedicated clinical psychology input in the ward and we were told that although finance has been secured, two rounds of recruitment were unsuccessful. This prompted alternative psychology in-reach to IPCU from existing adult services. The lack of psychology posts dedicated to mental health wards has been recognised as challenging. We were told there had been good input and intervention from local CMHT psychology colleagues, who have provided valuable staff guidance and formulation for individuals with challenging and complex needs.

MDT meetings took place weekly, and we found the documents supporting MDT meetings were detailed, in good order and gave a clear record of those in attendance. The MDT meeting template had a section to accommodate the individuals, carers and relatives' views and documented discussions as taking place. The template also included an open invitation for the individual to attend the meeting, and their decision to attend or not was recorded.

We were told the discharge co-ordinator regularly attended MDT meetings and discharge planning included involvement from community mental health teams (CMHTs), social work and the crisis resolution and intensive home treatment team from surrounding areas.

Use of mental health and incapacity legislation

On the day of the visit, all 10 individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was easy to find and in good order.

The individuals we spoke with told us staff explained the Mental Health Act and their rights while they were an inpatient in IPCU.

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. We found 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. Two minor discrepancies were highlighted to staff who assured us that these would be amended. We were told that audit of T2 and T3 certificates took place weekly. We would hope that these audits would pick up any future discrepancies.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. On the day of our visit, we were told no individuals had nominated a named person. We would like this role to be promoted in the ward and for staff to encourage individuals to nominate a named person. Ward staff, including the mental health officer (MHO), and advocacy, should discuss the importance and benefits of this role with the individual and these conversations, including whether they chose to nominate a named person or not should be recorded in their care records.

Recommendation 1:
Managers should ensure the named person role is promoted in the ward and individuals are encouraged to nominate a named person.

Rights and restrictions

The IPCU is a locked ward and has a locked door policy that is proportionate to the level of risk being managed in an intensive care setting.

We wanted to follow up on our previous recommendation regarding inappropriate placements of some individuals in IPCU and we were told there was a clear admission criterion which is adhered to. The ward recognised that there may be occasions when there is a requirement to use an IPCU bed for a patient not meeting this criterion. We were told this would be discussed with the clinical team before agreeing to admission. The Commission would like to be notified and kept updated on individuals transition to an appropriately based ward in these situations.

When we are reviewing patient files, we look for copies of advance statements. The term ‘advance statement’ refers to written statements made under sections 275 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. Health boards have a responsibility for promoting advance statements. Although we found some advance statements in the case records, we found no evidence of these being discussed with individuals who did not have them.

We would like to see increased prompting and promotion of advance statements in IPCU. This should be encouraged during the individual’s recovery and facilitated by an individual’s named nurse, highlighted at MDT meetings and included in discharge planning with encouragement from the MHO, and CMHT and supported by advocacy. Discussions with the individual should be documented in their care record.

Recommendation 2:
Managers should ensure there is raised awareness and promotion of advance statements and the benefits of these should be discussed with individuals throughout their stay in IPCU.

The Commission's *Rights in Mind*[1] 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

The IPCU unit had input from their designated activity support worker (ASW) and occupational therapist who worked closely to deliver therapeutic activities, such as cooking, relaxation groups, yoga, badminton and exercise, either in group or one-to-one sessions.

Feedback on individuals' activity preferences was gathered at weekly community meetings and added to an activity timetable. We saw a good level of ward activities being promoted and heard positive comments from individuals about the variety and benefits of activities on offer. We did have difficulty finding activity participation recorded on EMIS and 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 and if they did participate, if they derived benefit from doing so.

Recommendation 3:
Managers should ensure when activities take place, these should be documented in the continuation notes, including information on whether the individuals accepted or declined to participate and of any benefit gained from participation.

The physical environment

The ward is split into separate male and female areas with access to single-sex shared bathrooms and one ensuite bedroom in each of the areas. There was a dining area that doubled as a visiting area, an activity room and additional separate areas available to accommodate activities, such as a pool table and the use of gym equipment. The IPCU was bright, welcoming, clean and well maintained.

We found nurse leadership to be calm, confident and approachable which was emulated by other staff in the ward. There was a variety of welcoming and supportive wall art and features that gave an impression of staff being approachable and accessible. These included "getting to know staff and meet the team" which had photos of staff and included "staff likes" and a "farewell feedback wall" which

[1] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

included positive messages and views from individuals who had been discharged from the unit.

We also saw signposting to advocacy services, chaplaincy, various support services, such as Dundee recovery road map, carers groups, welfare advice, benefits queries and information on mental health conditions and symptoms. We recognised this contributed to providing reassurance and gave an impression of optimism and hope to newly admitted individuals.

Summary of recommendations

Recommendation 1:
Managers should ensure the named person role is promoted in the ward and individuals are encouraged to nominate a named person.

Recommendation 2:
Managers should ensure there is raised awareness and promotion of advance statements and the benefits of these should be discussed with individuals throughout their stay in IPCU.

Recommendation 3:
Managers should ensure when activities take place, these should be documented in the continuation notes, including information on whether the individuals accepted or declined to participate and of any benefit gained from participation.

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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