Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 19 November 2024

Where we visited

Ward 1 is a 22-bedded, mixed-sex, general adult psychiatric acute admission ward in the Carseview Centre. It provides admission beds for the Dundee West across NHS Tayside. Although the ward primarily covers Dundee West, we are aware that the three adult mental health wards have continued to admit individuals out with their geographical wards area and on the day of our visit, there were some admissions from the Perth and Kinross area. We were informed on this visit that there were two individuals with a diagnosis of learning disability in the ward, due to bed shortages in the learning disability assessment unit.

We last visited this ward in November 2023 on an announced visit. On the day of this visit, there were 21 people on the ward with one vacant bed. There were four people whose discharge was delayed as they were awaiting a further placement, or a social care package to be put in place.

We made four recommendations on our last visit. These were to address the cannabis use in the hospital grounds, the need for dedicated clinical psychology input, that all psychotropic medication was authorised where required, and to consider whether provision could be made for additional therapeutic space in the ward.

On the day of this 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.

We were pleased to hear about improvement work on the ward to involve carers in the test of change 'Triangle of Care' project. The aim of this project was to improve the carer experience and allow them to be more involved in an individual's care in a meaningful way. This involvement would then be captured in the individual's care plan. There were two staff identified from the ward who will be talking to carers and staff to discuss what this should look like and what should be included in the carers care plan. These staff members also planned to engage with carers groups in the community to discuss the project. The proposed plan is that this will be added to the ward standards when they are revised in June 2025.

Who we met with

We met with 13 people in person. We reviewed the care notes of 10 people. We also met with two relatives.

We spoke with the general manager, senior nurse, the charge nurse, the physiotherapist, and the locum psychiatrist. We also spoke with advocacy and the senior charge nurse separately, as they were not available on the day of our visit.

During our visit we also had the opportunity to look around the ward and speak with members of the nursing team.

Commission visitors

Sandra Rae, social work officer

Tracey Ferguson, social work officer

Dr Ahmad Allam, psychiatry trainee

What people told us and what we found

On the day of our visit, we were pleased to find many individuals who were willing to discuss their experience of 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 the reassurance they provide.” Other positive comments were that individuals felt “fully involved in their care” and others commented that the hospital was “the best they had been in.”

The majority of individuals we met with informed us they were aware of the contents of their care plans and met with staff during one-to-one meetings to discuss them. Some other individuals informed us they were not aware of their care plans, the legislation they were subject to, nor the time frames of this legislation.

We had also heard some comments about the strong smell of cigarette smoke on the ward, which many individuals found unpleasant, and this stopped them from “going into the garden for fresh air which helped them recover.” We were told of the smell of cannabis in the ward and garden area.

Individuals also spoke of vaping in rooms, and we saw some individuals walking through the ward with unlit cigarettes in their mouths. We were concerned to hear that there had been no improvement in this area, despite us making a recommendation on our last visit that this was to be addressed. The law to have smoke-free grounds and a ban smoking in or around hospital grounds has been in place since September 2022. We raised our concerns with senior managers on the day. They told us that this was an ongoing issue that they had been aware of for some time and were looking at ways to prohibit individuals from smoking in the garden area and vaping in their rooms.

The general manager was part of a working group to look at ways to stop smoking in the ward gardens and hospital groups. We discussed linking in with other parts of Scotland who had managed this successfully and we will continue to liaise with senior managers to hear how this progresses.

Staff informed us that they were conflicted by the smoking in the ward and garden area. Staff recognised how this affected others in the ward who were non-smokers as the garden area has a strong smell of smoke and access to the garden is through the communal lounge. However, they felt that a hospital admission was not the best time to restrict smoking. Nevertheless, as this is now law, the requirement for a smoke free environment should be enforced.

Recommendation 1:

Senior managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (Part1) to promote the provision of a safe, pleasant and therapeutic environment for all.

Feedback from carers was positive and they felt included in the care of their loved one. The relatives we spoke with found staff "very supportive" and "open to discuss different approaches to providing individual care for the person in hospital."

A relative informed us that the lack of psychology provision had "a massive impact" on the care of their family member. The relative also informed us that they had sourced this privately and commented on how receptive the multidisciplinary team were to include the psychologist in the individual's meetings, when appropriate.

We heard from staff that recruiting to psychology posts had continued to be challenging. Staff also informed us that there were new short-term psychology developments on the ward. There was a psychologist from Tayside who collaborated with individuals with a diagnosis of personality disorder. There was also a psychologist who was looking at the physical healthcare needs of some individuals on the ward.

Staff informed us of the complexity of supporting individuals with a learning disability in the ward and the challenges and risks that this could present.

Care, treatment, support, and participation

Care records

Although most individual care records and care plans were stored on the electronic record system, EMIS, some documentation, such as information around medical treatment was stored on paper records in the treatment room. We found EMIS relatively easy to navigate and most continuation notes were informative and linked to care plans.

Care plans

We saw examples of care plans that were holistic, provided a person-centred, descriptive account of individual needs and subsequent interventions, and found these linked with the information that was gathered from admission. There was evidence of care plans being regularly reviewed with the individual and wider family.

We were pleased to find the content of care plans gave the reader a good account of the individual's current and historical needs, which was helpful for staff who may not be familiar with an individual, or aware of their presentation or circumstances. We found that there was a wide range of detailed and person-specific care plans in place

for each individual and that these related to their mental and physical health, where relevant.

We found the majority of care plans evidenced individual involvement and individuals who wished a copy of their care plan were provided with this, however this was not documented in the continuation notes. It would have been helpful to have seen discussions about individual involvement and participation being revisited during care plan reviews and recorded in continuation notes or documented as a one-to-one meeting.

We were told five care plans were audited each month by either the senior charge nurse or charge nurse. Feedback on these audits was then shared with the relevant named nurse groups.

Risk assessments

We saw risk assessments that were detailed and provided good historical information, although the reviews were descriptive and there was a lack of clarity in how the risks were being managed. We also felt the addition of psychology would help with risk formulation and other psychological strategies to support the recovery of individuals on the ward. We heard how the service was revising their risk assessment and were looking to make improvements in this area.

Discharge planning

We were advised that the discharge coordinator post had been beneficial to support smoother progress towards discharge for individuals. Staff told us this approach had contributed to several improvements, including helping to reduce delayed discharges in some health and social care partnership areas.

There was a weekly meeting that adopted a service-wide supported approach to discharge planning, and included input from Dundee, Angus and Perth & Kinross health and social care partnerships (HSCPs). This meeting identified community support that was then presented at pre-discharge meetings.

We were told this 'test of change' was being conducted across the Carseview centre.

Multidisciplinary team (MDT)

The MDT in Ward 1 had a wide range of professional input. The MDT consisted of nursing staff, two locum psychiatrists, an occupational therapist (OT), activity workers, a pharmacist, a physiotherapist, and a chaplain. An MDT meeting took place weekly and from reviewing the care records, we were able to see evidence of individuals and their relatives attending along with other professionals who were involved in these weekly meetings. Where individuals did not attend, we noted that pre-prepared nursing feedback was gathered from one-to-one meetings with individuals, and this was included.

The MDT meeting template evidenced some detailed recording, however there were some gaps in the recording of known information, which compromised the completeness of the record. Senior staff informed us that this tool had changed recently, and they were supporting staff to complete it fully; they recognised this is an area for improvement.

During 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. Unfortunately, psychology remained a gap in the MDT. We were told these posts continued to be advertised however, had not been filled, and readvertising continued.

Although there were alternative approaches being tried, such as community psychology teams providing in-reach services to the ward, this arrangement had not been formalised and referrals were rarely made. We acknowledge the attempts made so far to recruit a psychologist, however the need for clinical psychology input to support the development of psychological therapies, and interventions across staff and individual groups, is an area that managers should continue to have as a focus.

A more formal arrangement for psychology provision from other areas should be put in place, while the vacancy 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 held in paper files.

On the day of our visit, nine of the 21 individuals in the ward were detained under the Mental Health Act. The individuals we met with during our visit had a variable degree of understanding of their detained status, where they were subject to detention. This might have been because their mental health had not fully recovered yet and they could not recall or retain previous discussions around their legal status.

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. Of the nine individuals detained under the mental health act,

six required either consent to treatment certificates (T2) or certificates authorising treatment (T3) to be in place.

Of the six, only three had valid treatment certificates which corresponded to their treatment. One individual had a T3 certificate with an error in how the treatment was to be administered, which had not been picked up by the team. A further two individuals had been given treatment without the legal authority in place, one of them for over a month. We had made a recommendation following our last visit that psychotropic medication required to be legally authorised, so were disappointed to find a lack of improvement in this area.

Recommendation 3:

Managers and members of the multidisciplinary team (medical, pharmacy, and nursing staff) must ensure that all psychotropic medication is legally and appropriately authorised. An audit system should be put in place to ensure compliance with this.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We found that one section 47 form had expired almost two months earlier and had been incorrectly completed. We were told that one person was receiving care under the AWI act, but there was no section 47 certificate authorising this.

Recommendation 4:

Managers and members of the multidisciplinary team (medical, and nursing staff) should ensure that where a person lacks capacity to consent to any intervention, that the appropriate legal framework is utilised where required. An auditing system should be put in place to ensure compliance with this

Rights and restrictions

A locked door policy remained in place for Ward 1, in order 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 were admitted to the ward informally and who did not need the door to be locked should also have been fully considered.

We were pleased to find there was clear information and instruction, as required, on how to come and go from the ward, which protected the rights of people who although vulnerable, were not subject to detention. The locked door protocol was displayed at the ward entrance and discussed at admission. We were pleased to

hear that this was reviewed regularly, discussed at shift handovers and recorded on the nursing office whiteboard.

We were unable to see information in relation to the garden area opening times. Information from individuals that we spoke with advised us that this could be inconsistent. It would be good practice and beneficial for all if discussions regarding rights and restrictions were recorded in the individual's care records.

When we are reviewing individual's 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 to promote advance statements. We were informed that none of the individuals in the ward had an advance statement, despite there being a satisfactory level of promotion and encouragement to complete these.

We heard that sometimes an individual's mental state had deteriorated to a point where they would not be able to complete an advance statement. However, we were pleased to hear that Ward 1 staff continued to highlight the benefits of these, when mental health symptoms stabilised and when individuals were preparing for discharge.

We were told that Ward 1 had strong links with Dundee Independent Advocacy Service (DIAS). Staff felt the relationship with advocacy 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.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We were pleased to hear the activity support worker, designated for Ward 1 had had a positive impact on structured activities for 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 focused on well-being and physical health. In addition to this, input from

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

occupational therapy provided a functional needs assessment to identify the level of support required for activities of daily living.

There was also evidence of physiotherapy input in the ward, promoting and encouraging gym sessions.

We heard positive feedback from the individuals who participated in these activities, and although this valuable resource provided beneficial input to the ward and individuals, we found nominal accounts of these activities documented in the care records.

We recognise the beneficial impact of purpose and routine in providing individuals with support and structure, as well as 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. We would also like to have seen the rationale for individuals declining activities, and if this was because they felt the activity was not suited to their preferences.

The physical environment

On the day of our visit, the ward was almost at full capacity, with 21 beds occupied. We were pleased to see that there was no longer a 'surge bed' in use. A surge bed is a bed which could be utilised for an emergency admission and we previously found these were in regular use.

Ward 1 previously had a shortage of space to accommodate several fundamental therapeutic activities that would contribute towards an individual's wellbeing. On this visit we observed an increase in therapeutic spaces, including an art room, a small gym and two interview rooms. These spaces have allowed more activities to take place on the ward, and for individuals to meet with visitors/relatives in privacy.

There was evidence of information promoting the work of the Commission and advocacy services on posters on the walls.

We noted that both the art room and interview rooms were also used for professional's meetings. This sometimes prevented some activities and reduced the opportunity for individuals to see relatives in privacy. There did not appear to be a booking system, nor did individuals know when the rooms were open for use.

Recommendation 5:

Managers should consider the use of space in Ward 1 and consider professionals' meetings being held elsewhere, to ensure therapeutic spaces are available to support and enhance individual wellbeing.

We found individuals being permitted to sit in the nursing office to use the telephone and speak to staff. In this room and one interview room there was confidential information held on a wall-positioned open whiteboard for all to see. We discussed the use of a board that provided confidential information in the interview room and nursing office.

Recommendation 6:

Managers should ensure the confidentiality of sensitive information is upheld, particularly in rooms which are used for different purposes.

We discussed the activity rooms as being an integral part of providing individuals with opportunities to engage in essential occupational activities, structure, and routine.

The garden area smelt strongly of cigarettes which impacted on others enjoying the garden area. Individuals were smoking regularly throughout the day in the garden area during our visit and there was a strong smell of smoke in the ward area.

Summary of recommendations

Recommendation 1:

Senior managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part1) to promote the provision of a safe, pleasant and therapeutic environment for all.

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 members of the multidisciplinary team (medical, pharmacy, and nursing staff) must ensure that all psychotropic medication is legally and appropriately authorised. An audit system should be put in place to ensure compliance with this.

Recommendation 4:

Managers and members of the multidisciplinary team (medical, and nursing staff) should ensure that where a person lacks capacity to consent to any intervention that the appropriate legal framework is utilised where required. An audit system should be put in place to ensure compliance with this.

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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 an individual's care, treatment, and support are 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