Mental Welfare Commission for Scotland

Report on announced visit to:
Carseview Centre, Ward 2, 4 Tom Macdonald Avenue, Dundee, DD2 1N

Date of visit: 26 February 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Ward 2 is based in the Carseview Centre. It is a 22-bedded mixed sex acute mental health admissions unit for adults aged 16-65 years old from the Dundee area.

On the day of our visit, there were 21 people in the ward and one vacant bed.

We last visited this service in November 2023 on an announced visit and made recommendations in relation to multidisciplinary team (MDT) meeting records that should include attendees, discussions and outcomes; that attempts to recruit a dedicated psychologist should continue; that care records should be reviewed to avoid duplication and ensure information is current; that the locked door policy was explained to people and that consideration should be given to adapting existing areas into therapeutic space.

The response we received from the service was that despite the implementation of new MDT templates for use across the Carseview site, these had not been fully embedded into regular practice. We were told that although psychology input for individuals comes from the community teams when required, there remains no dedicated psychologist in Ward 2. We were advised that paper documentation had been reduced to only the relevant hardcopies and most documents were stored electronically. A leaflet was in the process of being developed that would inform individuals and their carers of the locked door policy and their rights in Ward 2 and that the surge room, which was not a bedroom but had been used as this had been removed and returned to an individual or clinical area, depending on need.

On the day of this visit, we wanted to meet with people receiving care and treatment in Ward 2, to review their care records and monitor the progress in response to the recommendations from our last visit.

Who we met with

We met with and reviewed the care of 15 people, nine who we met with in person and six who we reviewed the care notes of. We also spoke with one relative.

We spoke with the general manager, the associate nurse director, the senior charge nurse (SCN), the consultant psychiatrist, nursing staff, health care support workers (HCSW), the activity support worker (ASW) and the physiotherapist.

Commission visitors

Gordon McNelis, nursing officer

Sandra Rae, social work officer

Audrey Graham, social work officer

What people told us and what we found

We met with several individuals who were keen to provide us with positive comments about staff. We were told they were “attentive”, “part of the healing process”, “they make you feel safe” and “they look after us”. There were also some less positive comments and we heard that staff were “abysmal” and “they won’t come near me”.

There were compliments about the ward environment where it was described as “relaxed”, “had a warmth about it” and “I don’t feel like I’m in a psychiatric hospital”.

A common theme we heard was that care, treatment and support was delivered in “a personal way” and that individuals were “clear about their goals”. Relatives told us “staff are informative and keep me abreast of updates”.

Care, treatment, support, and participation

Care records

Information on individuals’ care and treatment was held electronically and easily located on the EMIS system. Essential documents were duplicated and stored in paper copies in case of power outage. The Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) paperwork were in good order and stored electronically and on paper.

On the day of our visit, we wanted to follow up on our previous recommendation regarding unnecessary duplication of care records and that records were current and regularly maintained. Despite audits being in place, we found some paper documents that didn’t match those held electronically. We raised this with senior ward staff who assured us these documents would be updated to maintain consistency.

Our review of continuation notes found them to be of mixed quality, with thorough content noted at the time of the individuals’ admission although as their hospital stay progressed, we noted the recorded entries gave a basic account of the individuals’ presentation. A common theme we found was that there were entries documented that stated “kept a low profile” and “slept well”. We believe it is necessary for health professionals to be descriptive when recording clinical information and give a clear account of whether an individual’s mental health has shown signs of improvement, deterioration, or remains unchanged.

We were told the one-to-one discussions between individuals and nursing staff were planned to take place three times per week however, the frequency of these were unknown as they had not been recorded in care records as such. We did, however, see entries on EMIS that were clearly recorded as one-to-one discussions between nurses and individuals, albeit without the structure of a one-to-one, but more by the

way of a general conversation. Although we found this engagement helpful in gathering information, we would like to have seen the individuals' own views quoted or used in the continuation notes and the entry recorded as a one-to-one discussion. We would also have liked to see it recorded that if a discussion was offered but the individual declined to participate, then this should have been noted.

We saw a robust example of a one-to-one discussion between the responsible medical officer (RMO) and an individual which was detailed and focused on the views and thoughts of the individual. The RMO also included their impression of the individual during their discussion.

Recommendation 1:
Managers should ensure meaningful one-to-one discussions between nursing staff and individuals take place regularly. These should be descriptive, link with care plans and include the views of the individual. If individuals decline to participate in one-to-one discussions which have been offered, this should be recorded in their care records.

Although we found detailed risk assessments, we saw that these had not changed over a period of time. We acknowledge that there can be occasions where no additional risks are identified following the individual's admission however, we feel consideration should be given to the inclusion of changes or updates if these are relevant.

We noted there were no risk management plans in response to identified risks. We consider that clinical risk assessment and management plans are important documents for reviewing changes with the individual's presentation and the need for these should be understood and followed by clinicians, especially regarding changes to clinical circumstances under which specific risk assessments and an accompanying management plan are required.

Recommendation 2:
Managers should ensure that risk assessments and risk management plans are developed to reflect the risks identified during risk assessment and updated throughout the person's admission.

Care plans
We reviewed a number of care plans and found that these had been regularly reviewed, that they were person-centred and linked the historical and current needs that were identified during the admission and risk assessment process. We heard mixed views of individuals' participation in developing their care plans. We recognise that for some, their ability to engage and contribute to care planning may not be appropriate due to their clinical presentation, however we would expect this to be

documented at that time, with consideration given to when the individual would be encouraged to contribute at a time they were able to.

Recommendation 3:
Managers should ensure individuals and their carers are invited to contribute to the development of person-centred care plans. Whether a person chooses to participate or not should be recorded in care records and any decision not to participate this should be revisited throughout admission.

The Commission has published a good practice guide on care plans[1]. 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.

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 (HCSW), occupational therapy (OT), an activity support worker (ASW), physiotherapy and pharmacy.

On the day of the visit, we wanted to follow up on our previous recommendation regarding dedicated psychology input to Ward 2. Unfortunately, a dedicated psychologist to the ward remained a gap in the MDT, despite finances being secured for the post and two separate recruitment drives. The lack of psychology posts dedicated to mental health wards across the Carseview Centre had been recognised as challenging. We heard about the alternative option provided from existing community psychology services who provide in-reach to Ward 2 where this was required. We continue to be of the view that dedicated clinical psychology input to Carseview/Ward 2 would not only provide the clinical care needed for individuals of this valuable resource, but would also provide staff with guidance and support formulation for individuals with challenging and complex needs; we consider that this is an area that managers should continue to have as a focus. We therefore repeat the recommendation from our last visit.

Recommendation 4:
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.

On the day of the visit, we wanted to follow up on our previous recommendation regarding MDT meetings. We were told a new MDT and rapid run-down template had been implemented for all wards in Carseview. We found there was mixed quality in the recorded information. Some had minimal information on the actions required and

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

the planning of areas discussed, whereas others were robust and fully completed, with relevant information such as a record of those invited, their attendance, the individuals' views, a summary of one-to-one discussions, and whether the individual choose to join the meeting or not.

MDT meetings took place on a weekly basis and relatives were made aware of these reviews and invited to attend, if consent had been given by the individual for them to do so.

The rapid rundown meeting took place weekly. We found the records for these meetings were detailed and gave the reader a good understanding of the issues and risks that were discussed and of the clinical updates that followed.

Use of mental health and incapacity legislation

On the day of the visit, 12 people were detained under the Mental Health Act. All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment, were easily found and in order.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required.

During our review of T2 and T3 certificates, we found these in both electronic and hard copy format. We found most of these corresponded to the medication being prescribed however, we found discrepancies on two T3 certificates. We identified one prescribed medication that was not an authorised treatment and found an obsolete version that was stored both in paper files and electronically.

We raised this with the SCN on the day of our visit who advised that they would bring this to the attention of senior medical staff, where a review of the individual's treatment plan and request a second opinion designated medical practitioner would be considered. We were also advised that the older versions of a T3 would be replaced with the current certificate and that this would be dealt with promptly.

Rights and restrictions

On the day of our visit the access/egress door to the ward was locked. There was a locked door policy in place for Ward 2, advising that this was done to provide a safe environment and support the personal safety of everyone on the ward. We were satisfied that this was proportionate in relation to the needs for most of those in the ward.

Despite a previous recommendation that focused on ensuring there was a visible locked door policy, we were disappointed to see no policy or notification of the locked door policy was on display at the entrance to the ward.

Recommendation 5:
Managers must ensure that the locked door policy and protocol on door locking is clearly visible and available to individuals, visitors and staff. This should include information on how individuals who are informally admitted to the ward can come and go freely.

On the day of the visit, we wanted to follow up on our previous recommendation regarding the locked door policy being explained to individuals in the ward. We were told a leaflet was being updated to include information on the NHS Tayside locked door in mental health settings policy and given to either detained or informal individuals and their carers at the point of admission.

Although this would be helpful for individuals in making them aware of the process for access and egress to the ward at the beginning of their hospital stay, we would suggest that this discussion is revisited when their mental health had improved, and the individual has a better understanding of their rights. We were told these discussions had not taken place.

We would expect the locked door policy to be explained to individuals during a one-to-one discussion and for this conversation to be recorded in their care records and are therefore repeating the recommendation from our last visit.

Recommendation 6:
Managers must ensure the NHS Tayside locked door in mental health settings policy is explained to individuals who are either detained or informal in one-to-one discussions and that these discussions are recorded in the care records.

When we are reviewing individuals' 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. We were told that advance statements were promoted in the ward and saw that when appropriate, staff discussed these with individuals during their admission. We found that individuals' participation and follow-up discussions by staff with individuals about advance statements was variable, and would encourage staff to continue to promote the use of an advance statement so that individuals could consider them.

Activity and occupation

Ward 2 had activities that were facilitated by both OT and the ASW. Feedback and suggestions for activities were gathered from individuals during a weekly group and ensured that activities were person-centred and aligned with individuals' preferences.

The activities for the week ahead were available to view in a structured activity timetable and copies were visible throughout the ward. Activities included regular opportunities for individuals to participate in exercise classes, gym sessions and yoga. There was also karaoke, access to play football and pool, escorted walks in the hospital grounds and surrounding areas, access to groups in the community and a gardening group.

We were told the ASW prompted and encouraged individuals to participate in one-to-one and group activities and we heard positive feedback about the range of activities on offer. We found the care records relating to activities were brief, with minimal description and information about the activity or the individual's participation in these. We would like to have seen documented care records for activities that expanded upon the rationale for the activity and the individual's participation at that time, including information on whether they accepted or declined to participate. We raised this at our feedback meeting at the end of the visit.

The physical environment

Ward 2 is a U-shaped ward that has separate male and female single en-suite rooms on each side of the ward. On the day of our visit, we found the ward to be busy, with several multipurpose rooms in use for the OT, visitors and individuals.

Previously when individuals were admitted to Ward 2 and there was no bed immediately available to them, the person would stay in a 'surge bed'. On the day of our visit, we wanted to follow up on our previous recommendation relating to the impact of this. We were told that since our last visit, monitoring and review of surge beds has concluded and these were no longer required. We found this space had returned to its correct use as a visitor's room, where there are current considerations for it to be adapted to a tactile sensory room.

Ward 2 had access to a garden but we were disappointed to find upon viewing this area, individuals were smoking, unchallenged by staff, despite this now being against the law.

We raised this during our feedback meeting, and we were told it had been difficult to enforce the Scottish Government's NHS no smoking legislation. We were told that senior managers continued to liaise with other NHS Tayside services to look at ways to implement the smoke free legislation.

Recommendation 7:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

During our walk-round of the ward, we noted that in response to a previous recommendation, frosted film that had been put in place over the nursing office window, to hide confidential information, had since deteriorated allowing this information to be viewed by those outside the nursing office. We raised this with managers during our feedback meeting who assured us they would look at options to reinstall a cover to hide confidential information.

We also saw areas that required general maintenance which presented as safety hazards and posed an increased risk to individuals and staff. We raised this with staff who told us that although they had escalated these to the external property and facilities management provider some time ago but as yet, these requests had not been responded to, or actioned.

Recommendation 8:
Managers must follow up a response from facilities management to ensure that the outstanding repair and refurbishment work is undertaken as soon as is practicable to address the environmental risk presented to individuals and staff.

Summary of recommendations

Recommendation 1:
Managers should ensure meaningful one-to-one discussions between nursing staff and individuals take place regularly. These should be descriptive, link with care plans and include the views of the individual. If individuals decline to participate in one-to-one discussions which have been offered, this should be recorded in their care records.

Recommendation 2:
Managers should ensure that risk assessments and risk management plans are developed to reflect the risks identified during risk assessment and throughout the person's admission.

Recommendation 3:
Managers should ensure individuals, and their carers are invited to contribute in the development of person-centred care plans. Whether a person chooses to participate or not should be recorded in case records and any decision not to participate this should be revisited throughout admission.

Recommendation 4:
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 5:
Managers must ensure the NHS Tayside locked door in mental health settings policy is explained to individuals who are either detained or informal in one-to-one discussions and that these discussions are recorded in the care records.

Recommendation 6:
Managers must ensure that the locked door policy and protocol on door locking is clearly visible and available to individuals, visitors and staff. This should include information on how individuals who are informally admitted to the ward can come and go freely.

Recommendation 7:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage 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.

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