Mental Welfare Commission for Scotland

Report on announced visit to: Wards 1, 2, and the Mulberry Unit, Carseview Centre, 4 Tom MacDonald Avenue, Dundee, DD2 1NH

Date of visit: 27 November 2018

Where we visited

Wards 1, 2, and the Mulberry Unit are all general adult psychiatric acute admission wards in the Carseview Centre. All three are mixed-sex wards, with Wards 1 and 2 having 22 beds and Mulberry having 20 beds. Four of the beds in Ward 1 are for the advanced intervention service, a national specialist service providing assessment and treatment for patients from across Scotland with severe treatment refractory depression and obsessive compulsive disorder. We last visited this service on 22 November 2017, when we made recommendations about care planning, activity provision, the electronic records system, and issues relating to the environment. We received a response to these recommendations with clear details about actions being taken or planned.

On the day of this visit we wanted to meet with patients, look generally at care planning, and at the provision of care and treatment because it had been a year since our previous local visit, and because we were aware that a new electronic records system had been introduced during this period.

Who we met with

We met with and/or reviewed the care and treatment of eighteen patients.

We spoke with senior charge nurses and other members of the nursing staff on the wards, and also met senior managers, the associate nurse director, and the acting head of service with responsibility for mental health services at the end of the visit.

Commission visitors

Ian Cairns, Social Work Officer

Alison Thomson, Executive Director

Douglas Seath, Nursing Officer

Marry Hattie, Nursing Officer.

What people told us and what we found

Care, treatment, support and participation

Comments from the patients

Almost all patients we met spoke positively about their treatment in the wards, and about their interaction with staff. Several patients said specifically that they found nursing staff supportive and caring, and felt that they were treated with respect in the hospital. Some patients did tell us that, while they were generally able to talk to staff when they felt they needed to, they were aware that at times nurses were busy and perhaps were not able to respond immediately if a patient wanted to talk to them.

While we heard positive comments about contacts patients had with doctors, several patients also raised issues about the number of locum psychiatrists who have been working in the wards. We heard that some patients have had a number of changes of psychiatrist, and several patients clearly felt frustrated because of these changes which can make it difficult for patients to build a relationship with their psychiatrist. We also heard from patients about specific issues which can arise when there are frequent changes in the responsible psychiatrist. The Commission is aware that this is a national issue, because of ongoing challenges recruiting psychiatrists, but we were told by senior managers during the visit that NHS Tayside will continue to try to fill posts on a permanent basis.

Care planning

A new electronic records system has now been introduced in the service, and we reviewed a significant number of files on this new system.

The care plans reviewed on the day of the visit were variable in terms of the information recorded. We saw good quality care planning documentation in some of the electronic records with care plans, which were person centred and had a strong focus on recovery. We also saw risk assessments and risk management plans which were detailed and well completed. In some individual patient records, though, we saw care planning information which was generic, and lacked details about specific interventions and care goals. We discussed this issue with managers on the day of the visit, and we heard about the programme of care planning documentation audit and about work to develop care planning standards. We feel that a continuing focus on this issue will be beneficial within the service.

Recommendation 1:

Managers should ensure that care plan interventions are detailed and measurable, and that care plan audits focus on this specific issue.

Participation

In most individual files which we reviewed, it was recorded that patients should have regular one-to-one time with a nurse. In some files we saw that this was clearly recorded, but in other files it was difficult to find evidence that staff were spending time talking to patients on a one-to-one basis. We feel that for many patients it is important that they are able to speak to nursing staff on a one-to-one basis regularly, and that this will help patients feel involved in decisions being made about their care and treatment. We also found it difficult to see evidence in many files that patients had actively participated in developing their individual care plans. We understand that evidencing this in electronic records systems is not straightforward, but we would expect to see more information recorded about how involved patients are in discussions about their care and treatment.

We also saw that information recorded in files about regular multidisciplinary team (MDT) meetings was variable. Some MDT records were good, with information about who had been involved in the meeting, but in some files it was not clear whether patients had participated in the meeting.

Recommendation 2:

Managers should ensure that patient participation in one-to-one discussions with nurses, in care planning, and in discussions about their care and treatment is evidenced in the electronic record.

Use of mental health and incapacity legislation

Paperwork relating to the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) was filed appropriately and was easy to access. We reviewed forms for consent to treatment under the Mental Health Act (T2 and T3 forms), and forms we reviewed were up to date, authorising medication appropriately. We were also pleased to see evidence of reviews by the pharmacist, with the pharmacist recording where medication was appropriately authorised.

Rights and restrictions

Patients in the three wards continue to have good access to independent services. A number of the patients we met during the visit were detained under the Mental Health Act, and they told us that they knew what their rights were and felt their rights had been explained to them clearly.

Activity and occupation

Several patients told us about activities they participated in, and there were positive comments about the input from occupational therapy and about art groups. Several patients though, particularly in Mulberry, spoke about the lack of activity provision and about feeling bored in the ward. We heard from patients in Mulberry how they could not access gym facilities on the site because there is no physiotherapy input into Mulberry. On our last visit we felt it was important that patients receiving care and treatment as inpatients had access to activities which provide stimulation and also opportunities for physical exercise. Comments we heard from patients on the visit, and from staff, suggest there are still issues about limited activity provision.

Recommendation 3:

Managers should review activity provision across the three wards again and look at how provision can be enhanced.

The physical environment

Patients in Mulberry Unit have no direct access to a garden area and some patients in Ward 2 also told us that, while they can access the garden directly from the ward, access to the garden can be very limited. Patients also raised a number of other issues about the physical environment in the ward. For example, we were told by some patients in Ward 2 that the layout of furniture in the lounge areas can feel very regimented, and can make it difficult for patients to chat informally together in a group.

Several patients in Mulberry Ward told us that they did not feel safe when they were in their bedrooms overnight because they could not lock their bedroom doors. Several patients also told us that, while every bedroom has en-suite facilities, they feel uncomfortable with the lack of privacy because toilet doors have been removed. We were also told by several patients that toilet seats were being removed from en-suite bathrooms. Several patients also commented on the fact that they found it difficult to get fresh air in their bedrooms, because windows are locked and cannot be opened.

We discussed these environmental issues with senior managers at the end of the visit. We were told that a number of changes had been made to the environment in the three wards following assessments of potential ligature risks. We also heard that options for addressing some of the issues raised by patients were being considered.

Recommendation 4:

Managers should ensure that any corrective work to the ward environment to address potential ligature risks maintains the dignity and privacy of patients.

Any other comments

There has been considerable coverage about the Carseview Centre in the media during 2018, and perhaps unsurprisingly we did hear from staff that morale in the unit has been affected. We also heard, though, from staff who have been able to participate in values-based reflective practice (VBRP) that this has provided them with valuable support. VBRP is a model of group reflection and supervision which has been developed by NHS Scotland, and in Carseview hospital chaplains have been involved in facilitating VBRB sessions for staff. It was clear from the feedback we heard from staff who have participated in these sessions that they feel the sessions provide clear benefits. The Commission would encourage NHS Tayside to look at how more staff working in the service can be involved in sessions.

Before this visit to Wards 1, 2, and Mulberry Unit, the Commission had been aware that, during 2018, an increasing number of informal patients had had to be admitted to the intensive psychiatric care unit (IPCU) in Carseview because no beds were available in any of the three admission wards. An IPCU is designed to provide intensive treatment and interventions where inpatients are more acutely unwell and may be presenting with an increased level of clinical risk. IPCUs generally have a higher ratio of staff to patients and often have a locked door, and the environment in an IPCU will be more restrictive than in an adult admission ward.

The Commission is concerned if people who do not need to be detained in hospital are admitted to a more restrictive environment because of lack of beds in other more appropriate wards. If an informal patient is admitted to IPCU, then the patient and staff need to be clear of the patient's status and about their right to leave the ward should they wish to do so. The Commission is satisfied that this information has been provided to informal patients who have been admitted to the IPCU in Dundee. We also heard that work is being undertaken by senior managers to look at issues around bed flow and bed management within Carseview, and we heard that managers hope that this will reduce the number of times when an informal patient has to be admitted to the IPCU in the future. We would want to receive updates about this work from NHS Tayside when it has been completed.

Summary of recommendations

1. Managers should ensure that care plan interventions are detailed and measurable, and that care plan audits focus on this specific issue.

2. Managers should ensure that patient participation in one-to-one discussions with nurses, in care planning, and in discussions about their care and treatment is evidenced in the electronic record.

3. Managers should review activity provision across the three wards again and look at how provision can be enhanced.

4. Managers should ensure that any corrective work to the ward environment to address potential ligature risks maintains the dignity and privacy of patients.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

ALISON THOMSON
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 MWC 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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