

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Wards 1, 2 and the Mulberry Unit at Carseview Centre, 4 Tom McDonald Avenue, Dundee DD2 1NH

Date of visit: 22 November 2017

Where we visited

Wards 1, 2 and the Mulberry Unit are all general adult psychiatry acute admission wards in the Carseview Centre. Ward 1 and Ward 2 have 22 beds, whilst Mulberry Unit has 20 beds. All wards are mixed sex. Four of the beds in Ward 1 are beds for the 'Advanced Interventions Service'. This is 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 Wards 1 and 2 on 5 November 2015, when we made recommendations about care planning and providing information to patients. We received a response to these recommendations which indicated that care plan audits were being carried out regularly, and that information about the availability of translation services was circulated to all wards.

We last visited the Mulberry Unit on 4 January 2016. We made recommendations about care planning and about the availability of responsible medical officers (RMO). We received a response from the service telling us how they would evidence the participation of patients in care planning, and about the process they put in place to provide RMO cover for absences.

At the time we visited Mulberry Unit in 2016, this was in the new mental health unit which had been built at Stracathro Hospital in Angus. The ward there was temporarily relocated in February 2017, with Mulberry Unit transferring then to an empty ward at the Carseview Centre. Mulberry Unit continues to be the ward for patients from Angus, and is currently still located in the Carseview Centre.

On the day of this visit we wanted to look generally at care planning and about the provision of care and treatment, because it had been two years since our previous local visits to the adult acute admission wards.

Who we met with

We met with and/or reviewed the care and treatment of 14 patients, and also met with one relative.

We spoke with the senior charge nurses and the service manager, and also met several of the consultant psychiatrists working across the three wards.

Commission visitors

Ian Cairns, Social Work Officer

Dr Mike Warwick, Medical Officer

Susan Tait, Nursing Officer

Graham Morgan, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

Comments from patients

During the visit we heard a number of positive comments from patients about the treatment they were receiving, and about their interactions with staff in the ward. People spoke about staff being approachable and supportive, although we did hear from several patients that staff at times appeared to be very busy, which limited the time they could spend with patients individually.

Care planning

The Commission has previously commented on the variability of written care plans recorded in the electronic record system in the wards. We had previously been told that a new electronic records system was to be in place by Autumn 2017, and we expected to see this being operational on this local visit. There have been some delays though in introducing the new system, which will now not be in place until later in 2018.

We found that the care plans reviewed on the day of the visit were variable in terms of the information recorded. We did see evidence of care plans being evaluated, and of detailed and very person-centred plans. We saw good records in files of the multidisciplinary team (MDT) review meetings. We also saw a number of plans, though, which were very limited, and in some cases plans consisted of a list of statements summarising the patient's needs, with no information about actual interventions or how to deliver care and treatment to meet a specific need.

In the current electronic records system, care planning information is entered in casework screens which are headed, risk assessment, and risk management, plans. In a number of cases this seems to lead to the care planning approach feeling as if it is primarily a risk management and process driven approach. Comments from some staff also indicated that they felt frustrated spending time updating information on the current electronic records system, and this was impacting on the time they could spend interacting with patients.

During the file reviews we undertook we saw some examples of good recovery care plans. One patient also told us how they had sat down with their named nurse and spent some time with them developing their own recovery plan. However, one patient also told us that they had simply been given a copy of a blank recovery care plan form to complete by themselves, and that they would have wanted to go through this process with support from ward staff. We also saw that in a significant number of cases, patients had indicated that they did not want to complete a recovery care plan, and in such cases we would have hoped to see examples of how there could be a

more recovery focussed approach in care planning, when patients are reluctant to engage in the process of completing a recovery care plan.

Communication between medical and nursing staff in Ward 2

During the visit we were told that medical staff are making entries in the electronic record system in Ward 1 and in the Mulberry Unit, but this is not happening in Ward 2. We heard from staff in Ward 2 that this can have an impact on communication between medical and nursing staff. We feel there may be potential patient safety issues if contemporaneous entries are not made by doctors in records.

We discussed this on the day of the visit, and were told that this issue has been raised on a number of occasions with senior management in NHS Tayside and that the issue has still to be resolved. We also raised the issue at the end of year meeting with NHS Tayside on 7 December, and we know that work is being carried forward across the general adult psychiatry in-patient wards, to develop a consistent approach to recording information in patient records.

Recommendation 1:

Managers should continue to audit care planning documentation, to ensure that plans are person-centred, and have appropriately detailed information about specific interventions required to deliver care and treatment.

Recommendation 2:

Managers should ensure that work to introduce the new electronic records system has a focus on person-centred and recovery focussed care plans.

Recommendation 3:

Managers should ensure that the issues which have previously been raised within the service, about medical staff not using the electronic record system in Ward 2, are addressed.

Use of mental health and incapacity legislation

Mental Health Act (MHA) paperwork within files seems to be well maintained, and was easy to access. We did note that consent to treatment forms (T2) and forms authorising treatment (T3) were not always filed with the drug charts, and would suggest that it is good practice for copies of T2 and T3 forms to be with the drug charts. We also noticed in two cases that medication was being changed, which would not have been authorised by either the T2 or T3 form which was in place. In each case the psychiatrist was aware of this, and had requested a visit from a designated medical practitioner (DMP) to authorise changes.

Rights and restrictions

Patient in the three wards seem to have good access to independent advocacy services, and several patients told us about the support they received from advocacy.

The Carseview Centre is a standalone building, and because the general reception area in the building does not have staff cover in the evening or overnight, the main door to the building is locked after 7.45pm. Any patient who wants to come into the building after that time has to use an entry door which is answered by staff from the intensive psychiatric care unit (IPCU).

When a patient is not detained in hospital, but is receiving inpatient care and treatment on an informal basis, they should be able to leave the hospital without being restricted. We heard comments from staff and from patients during the visit which suggested that there is some confusion amongst staff about how decisions should be made to allow patients to leave the wards, and to go out of Carseview Centre building when the main door is locked. There is a vending machine area out with the wards, but in the main building, which some patients feel they have restricted access to when the main building is closed. There also seems to be a lack of clarity about whether patients could leave the hospital grounds to smoke when the main building is closed.

We discussed this with the service manager at the end of the visit. He explained that the hospital site is now a no smoking site, so that people have to leave the grounds to smoke. He also said that there is an expectation that part of the care planning process involving individual patients should be about preparing anticipatory care plans, which are specific to each patient, and which have specific information about time out of the ward and out of the hospital grounds. From the discussions we had with patients and staff on this visit, there did not seem to be an agreed understanding across all wards about this issue.

Recommendation 4:

Managers should ensure that there are clear and consistent arrangements to allow patients who are not detained to come and go from the wards, and from the hospital building during periods when the main door to the building is locked.

Activity and occupation

Information about activities was available in wards, and we heard a number of positive comments from individual patients about activities they participated in. Several patients said that they felt there was not enough to do in the wards. We also heard that input from occupational therapy (OT) and physiotherapy services has been reduced in the wards, and that this is having an impact on activities provided. In the case of the Mulberry Unit, a physiotherapy post is vacant, and as a result patients are not able to access the gym facilities which are on site. We also heard that some allied health professional sessions in the inpatient service have been reduced, with the sessions now being allocated to community services. We feel it is important that patients who are receiving care and treatment as inpatients have access to activities which provide stimulation, and also opportunities for physical exercise.

Recommendation 5:

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

The physical environment

When the Mulberry Unit was based at Stracathro Hospital it was in a new build facility, with plenty of space and good access to gardens. The environment in Mulberry Unit at Carseview is more cramped and is much less attractive. We heard comments from both staff and patients about the fact that the building is much less comfortable and pleasant. Patients in Mulberry Unit also do not have the same ready access to a secure garden area which patients in Ward 1 and 2 have.

Communal areas in the three wards are quite clinical and sparse, with one patient telling us that the seating was like sitting in a health centre waiting room, and that it was not comfortable. We heard that some changes have been made to the physical environment in the three wards as a result of ligature risk assessments which have been completed. We were told that bedside chairs have been removed from rooms as they were considered a ligature point, and that some windows in bedrooms have to remain locked following individual risk assessments, because of ligature risks. We also heard that bedroom doors can't be locked by patients, and that there are no doors in the en-suite facilities in bedrooms, and that someone can therefore enter individual bedrooms when a patient is in their en-suite bathroom.

We heard several comments from staff which indicated they felt that there was an extremely risk averse approach now being taken with regard to the physical environment in the wards, and that this could inhibit recovery focussed care and treatment, and proactive approaches to risk management. This was discussed with the service manager at the end of the meeting, who advised that the design of the environment was being taken through a working group which was considering adaptations and changes across the service seeking to strike a balance between management of risk and patient experience. He further advised that core members of these groups included senior charge nurses and consultant psychiatrists.

Recommendation 6:

Managers should ensure that there is full discussion and consultation with medical and nursing staff about any proposed environmental changes, and that any changes do not impact on the quality of the physical environment in the wards, inhibit positive risk taking or compromise dignity of patients.

Any other comments

During the visit we were told that people in Angus do not have the same access to intensive home treatment services as people who are resident in Dundee and Perth. This may affect the length of inpatient stays in the Mulberry Unit, as it can be more

difficult to look at earlier supported discharge, and it may also be leading to some admissions which could have been preventable. This is an issue which the Angus Health and Social Care Partnership is aware of, and we would hope that this will be addressed in the future.

Summary of recommendations

1. Managers should continue to audit care planning documentation, to ensure that plans are person centred, and have appropriately detailed information about specific interventions required to deliver care and treatment.
2. Managers should ensure that work to introduce the new electronic records system has a focus on person centred and recovery focussed care plans.
3. Managers should ensure that the issues which have previously been raised within the service, about medical staff not using the electronic record system in Ward 2, are addressed.
4. Managers should ensure that there are clear and consistent arrangements to allow patients who are not detained to come and go from the wards and from the hospital building during periods when the main door to the building is locked.
5. Managers should review activity provision across the three wards, and look at whether provision can be enhanced.
6. Managers should ensure that there is full discussion and consultation with medical and nursing staff about any proposed environmental changes, and that any changes do not impact on the quality of the physical environment in the wards, inhibit positive risk taking or compromise dignity 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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777

e-mail: enquiries@mwscot.org.uk

website: www.mwscot.org.uk

