Mental Welfare Commission for Scotland

Report on announced visit to:
Carseview Centre, Learning Disability Assessment Unit,
4 Tom McDonald Avenue, Dundee, DD2 1NH

Date of visit: 27 November 2024

Where we visited

The Learning Disability Assessment Unit (LDAU) is a mixed-sex, 12-bedded assessment unit for people with a diagnosis of learning disability in Carseview Centre. It primarily provides admission for people living in Dundee City, Angus, Perth and Kinross. We were informed that a decision had been taken by senior managers for the service that in future, the unit will only have 10 beds open for admission.

On the day of this visit there were nine individuals in the unit, all subject to compulsory measures. Seven individuals with a learning disability were still in hospital due to their discharge being delayed. The term 'delayed discharge' is used when a person, who is clinically ready for discharge from inpatient hospital care, however, continues to occupy a hospital bed usually because of delays in securing a placement in a more appropriate setting.

Whilst the Commission acknowledges that some issues remain out with the control of the health authorities responsible for the care of individuals, discharge planning should begin on admission. Delayed discharges impact negatively on both the individuals who are delayed, as well as on those who require admission to specialist areas but are unable to be admitted due to lack of beds.

We last visited this service in November 2023 and undertook an announced visit. On this visit we made nine recommendations. These were around the documentation of one-to-one discussions between individuals and staff, the completion of the multidisciplinary (MDT) meeting document, the provision of easy read care plans where appropriate, the involvement of relatives and carers in care planning, the completion of section 47 certificates and associated treatment plans, and an audit in place to monitor compliance, that specified person restrictions be correctly authorised and the required notification should be sent to the Commission, that participation in activity should be documented in care records, including a record of engagement and any benefit from participation, that plans be progressed to increase areas where therapeutic activities can take place and that individuals bedrooms were regularly cleaned and maintained to an acceptable standard.

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 unit since our last visit. We heard about the progress made and the new senior leadership in the unit, which was supporting positive change. We also heard there were plans in place to relocate to another hospital site in 2025.

We had a follow up meeting with senior managers after our visit where we discussed our findings and had the opportunity to hear about the challenges the service had experienced, and the proposed changes they were considering.

We were pleased to hear that the unit was undertaking physical health checks in line with the recommended Scottish Government annual health checks. The newly qualified nurses had been trained in completing these and will be undertaking them over the next year.

During our visit we saw a white board which showed improvement works, and a story/journey of LDAU progress over the year. There were other positive outcomes with staff engaging in further training, the establishment of 'ward champions' and staff allocation sheets which ensured there was clarity in the staff members role for the day. The senior charge nurse (SCN) had promoted values based reflective practice and the unit had a manual handling and basic life support (BLS) trainer. The unit also had a welcome board, with pictures on the wall which made the environment feel more homely.

Senior managers informed us of there being a new process in relation to delayed discharges, which they were in the initial stages of implementing. Delayed discharges were a concern raised by those we met with.

Who we met with

During our visit we met with, and reviewed the care of five people, four of whom we met with in person. We also met with one relative and received correspondence from another relative.

We spoke with the service manager, the SCN, the charge nurse, staff nurse, and activity co-ordinator. We also met with the occupational therapist, advocacy worker and other members of the nursing team.

Commission visitors

Sandra Rae, social work officer

Paul MacQuire, nursing officer

Katherine Liddell, social work officer

Andrew Jarvie, engagement and participation officer

What people told us and what we found

On the day of our visit, we were pleased to meet with individuals who were willing to discuss their experience of care and treatment in the LDAU. The feedback we received was mixed.

Individuals we met with told us that LDAU staff “are helpful”, “supportive”, and “keep me safe”. A few individuals spoke of enjoying one-to-one trips out of the unit. We were informed that individuals had a nurse they could speak with however, some were of the views from those we spoke with were that the nurses were “always too busy” to spend time speaking with them. Other individuals spoke of there being “a lack of activities” and “not being able to get out of the unit”. We heard that being delayed in hospital for a long time was a stressor for individuals; they informed us that “nothing seems to change”. This was distressing for one individual; as they waited, they worried about what was going to happen and when it would happen however, they felt there were no concrete answers.

We observed nursing and occupational therapy staff demonstrating a supportive relationship with individuals and a positive way of working with those who had enhanced communication needs. We found that the needs of individuals were identified and addressed during periods of distress, with minimal disruption in the unit.

Individuals told us they found the regular one-to-one meetings with their named nurse and doctor helpful. They indicated that staff approached them to gather their views prior to the weekly MDT meeting. Some individuals we spoke with said that there was limited feedback from MDT discussions, and they would have liked to hear more about the MDT response to their views, and for them to be made aware of and actively included in current plans for their care and treatment or in discharge planning.

Comments from relatives/ carers

We were informed by a relative that they did not find the MDT meeting helpful, nor welcoming. The views from relatives were that the environment was lacking basic requirements and that activities detailed in the care plan were not always being delivered for their relative. One relative felt that some of the policies in the unit prevented person-centred care. The relatives were keen that the Commission were aware of their views.

Comments from staff

Staff told us they felt supported and the training opportunities allowed them to be more informed and confident in their role. They found having time off the unit where there was no disruption to their breaks to be of benefit, as they could relax.

Previously they took their breaks on the unit, and regular interruptions prevented them from having a proper break or having a meal.

Care, treatment, support, and participation

Care records

Information on individuals' care and treatment was accessed via the electronic record system, EMIS. There was also some information, such as authorisation for medical treatment held in paper notes. Any paper notes were scanned onto EMIS to ensure consistency and the records were comprehensive. We found the system easy to navigate.

Our review of the information on EMIS found that the quality of the care records had improved, with risks recorded in detail throughout. We found that although the positive behavioural support (PBS) plans were excellent, we would have preferred to see them and the nursing care plans reflected more robustly in the care records. We saw evidence of the named nurse engaging with an individual to gain their views on care plans reviews. However, we found one-to-one discussions were still not being recorded consistently.

Recommendation 1:

Manager should ensure that one-to-one discussions between individuals and staff are documented consistently in the care records.

The care records noted that some individuals in the unit could experience significant stress and distress, leading to increased clinical risk related to self-injury, as well as verbal, and physical aggression. It was positive to note that all members of the MDT were actively involved in providing support, care, and treatment to individuals at these times.

We found the medical care records for individuals to be of a high standard.

While we found that most care records were comprehensive, person-centred, and provided information on how the individual had spent their day, some lacked this level of detail and focussed on personal care interventions. This made it difficult to see how the individuals presented throughout the day and what therapeutic interventions they had engaged in. We found some duplication with, and inconsistencies in, the paper and electronic notes and felt it would be of benefit to ensure both sets of notes are accurate and minimise duplication whenever possible.

Recommendation 2:

Managers should ensure there is regular review and audit of paper and electronic records to ensure they are accurate and minimise duplication.

We were pleased to see that the physical health care needs of individuals were being addressed and followed up appropriately by the associate physician and medical staff, along with their mental health needs.

Care plans
During our visit we saw examples of care plans that were holistic, provided a person-centred, descriptive account of individual needs and subsequent interventions. We found these linked with the information gathered from admission. There were also care planning champions in the unit, who were undertaking regular audit and linking in with Tayside Quality Improvement team.

We were pleased to see easy read care plans had been introduced and feedback had been requested from legal proxies to help further improve these.

We found PBS plans that were well designed, comprehensive, and person-centred. We found most care plans were holistic. However, the individual's voice or view was not always clear in them. We would have liked to have seen progress towards the care plan goals recorded in the continuation notes.

We found that risks which were identified during the admission assessment process were included in risk assessments, risk management plans and care plans. These gave a good understanding for those who were unfamiliar with the individual's historical and current circumstances.

Multidisciplinary team (MDT)
Care and treatment in the LDAU is provided by the MDT. This team consists of the responsible medical officer (RMO), speciality doctor, junior doctor, psychology, dietician, occupational therapist, advocacy, nursing staff. The MDT meets weekly.

At the time of our visit, there was no physiotherapy support in the LDAU. This was raised by staff and individuals as having an impact on the treatment for individuals who would have benefitted from using the hospital gym. We heard that this could not be accessed as no one was trained to supervise or support individuals doing so. Staff and individuals felt that using the gym would bring positive health benefits and would be a way to effectively manage stress and distress.

Recommendation 3:
Managers should consider physiotherapy input to the unit to support individuals to use the gym.

We were told that an MDT meeting proforma has been trialled with additional changes. We noted some comprehensive recording however, there were times when there were gaps in the recording of known information, which compromised its effectiveness. We did not find clear evidence of the individuals' views in the MDT notes, nor were they invited to attend MDT meetings. We did note that advocacy

involvement in the MDT meeting was helpful. Relatives and carers did, on occasion, attend MDT meetings.

The delays with discharges were a significant issue in the unit, with seven people waiting for discharge. We found no evidence of this being noted in the MDT meeting. We discussed this in our follow up session with the senior leadership team who acknowledged that improvements were still required to ensure the correct professionals were invited to attend the MDT meeting and that relevant discussions were recorded.

We were advised of the proposed work in relation to delayed discharges but heard that this was its initial stages. We would like to see this work being progressed as a priority and we hope to see the developments in this area on future Commission visits. We will also request regular updates from the service on progress with their delayed discharges.

Recommendation 4:
Managers should ensure that all key professionals are invited to attend the MDT meeting, that the proforma is fully completed, that the views of the individuals are incorporated, and the actions being taken to progress the delayed discharge of each person are recorded.

Use of mental health and incapacity legislation

On the day of our visit, nine individuals who were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We found the forms relating to each detention stored electronically on EMIS. One individual had a good awareness of their rights.

A person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We found no named persons had been nominated, according to records. Staff explained that this was due to these individuals being unable to nominate a named person due their clinical presentation.

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 reviewed the prescribed medication for all individuals in the unit, as well as the authorisation of treatment for those subject to the Mental Health Act and found that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

Medication was prescribed on the hospital electronic prescribing and medicines administration (HEPMA) system. T2 and T3 certificates authorising treatment were

stored on EMIS, but we also found paper copies of all T2 and T3 certificates kept in the treatment room, so that nursing and medical staff had easy access to, and an opportunity to review, all T2 and T3 certificates when dispensing medication.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

The individuals in the unit were all subject to welfare guardianship under the AWI Act. However, we found consultation with the proxy was not recorded in any of these cases. This area requires urgent attention to ensure compliance with the AWI Act. We discussed this in our meeting with the senior management team and the need for a robust audit process to ensure that all treatment paperwork is completed as appropriate. There was recognition that there was no audit process in place to monitor this at this time. We found all welfare and financial guardianship paperwork was in place.

Recommendation 5:
Managers and medical staff must introduce an audit process to ensure that AWI Act processes are correctly followed, and legal documentation is completed appropriately.

Rights and restrictions

The LDAU continues to operate a locked door, to provide a safe environment appropriate with the level of risk identified with the individuals on the unit. The locked door policy was clear and visible at the entrance to the unit and was discussed with the person and all relevant proxies on admission. We were pleased to hear this was reviewed regularly.

Of the individuals we met with, we found that they had a mixed understanding of their rights, as a detained person. We found letters to individuals who were detained under the Mental Health Act that provided information on the order they were subject to and information on how to exercise their rights. We noted the frequent visits by advocacy was positive for the unit and provided support for individuals in having their rights upheld, as well as supporting people who were not satisfied with the restrictions to their liberty.

We were, however, unable to see any support in relation to promoting rights and delivering rights-based care documented within the care records. It would be good practice and beneficial for all if discussions regarding rights and restrictions were recorded in the individuals' care records.

During our visits, 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. One of the individuals we met informed us they had an advance statement and from review of the care records, we found a copy of this. In our review of the care records, and during discussion with some individuals, we found that most people on the unit were not able to make decisions regarding their care and treatment.

When reviewing care records, we saw that some individuals were subject to continuous intervention (CI). We were concerned to read, that despite enhanced levels of intervention to support some individuals manage their distress, this intervention had not prevented self-harm occurring. There was ongoing MDT support to manage these situations and the complexity of some individuals on the unit.

We were unable to see evidence of conversations that the RMO had with individuals about their legal status, and who were subject to compulsory measures that had been recorded in their care records.

During our visit there were four people who were subject to seclusion. There is no definition of seclusion in the Mental Health (Care and Treatment) (Scotland) Act 2003. On the day of our visit, we found that staff's understanding of their practice that the Commission would have considered to be seclusion was not always clear for them. The Commission published a good practice guide on the use of seclusion in October 2019. This guidance was written for situations where those professions may be considering using seclusion pathway treatment.

While we do not advocate the use of seclusion as a first-line response to aggressive behaviour, it must only be used in the context of an approved policy on the management and prevention of violence, produced by the relevant NHS board for each hospital. We do, however, acknowledge that seclusion may be necessary and services must ensure that it is properly monitored with the aim of reducing risk and preventing harm. The principles of least restriction and benefit to individuals must always be applied and it is also important to support and debrief the person after an incident of seclusion. When reviewing the care of an individual who was subject to seclusion, we found it was care planned effectively and reviewed accordingly.

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 including discharge from hospital.

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

Activity and occupation

We were pleased to see there was a designated area where activities took place over seven days, which was one of the previous recommendations from our last visit.

The activities on offer in this area were mainly art sessions or board games. There was a larger lounge with a TV, and activities also took place in this area. We heard the activities co-ordinator worked over a seven-day period and undertook one-to-one activities with individuals. The activities co-ordinator used one day per month for administration and planning, including assessing people's suitability for group or solo outings. We were informed that individuals recently went pumpkin picking and to a goat feeding session, which they enjoyed. During our visit, we met an individual who was excited about their one-to-one trip to the cinema. Regular participation in these activities and others, such as shopping, were evidenced in the care records.

Although there appeared to many activities on offer, some people felt there was nothing meaningful to do. We were able to see evidence of occupational therapy working with individuals.

We would also like to have seen evidence in the care records where activities had been offered and declined. This would support a more personalised approach in designing activities for each person, and measure what activities met the individual's preferences and aspirations.

Recommendation 6:
Managers should ensure that there is recording of activities being offered and those which are declined. This will encourage ongoing review of activities within the unit that are person-centred and meaningful for all.

The physical environment

On the day of our visit, we were keen to see if our previous recommendation in relation to the physical environment had been met. This was to progress plans for surplus areas in the LDAU to be developed into opportunities for increased therapeutic activities to take place and to ensure individuals' bedrooms were regularly cleaned and maintained to an acceptable standard. We found aspects of this recommendation had been met in relation to space for therapeutic activities and could see there had been efforts made to attempt to maintain the bedrooms to an acceptable standard.

The unit environment was welcoming with pictures on the wall and an open activity area at the front of the unit. We were pleased to see the anti-ligature work had been completed in the bedrooms. All bedrooms were ensuite and there was ongoing work in terms of maintaining the bedrooms and repairing damage caused by individuals who were experiencing acute levels of stress and distress.

The unit had sourced an external company who came in regularly to repair the damage, and we saw evidence of this during our visit. The damage in the unit had a significant impact on the budget. We saw some specialist furniture had been sourced to safeguard individuals and staff and minimise damage. We found some rooms cluttered which had an impact on the hygiene levels in these areas.

We were pleased to find a room had been converted to a sensory space in a quieter area of the unit and that there was a dedicated area in the unit for activities. We found this area at the front entrance of the unit to be busy, and at times, it appeared a little chaotic, as it also appeared to be a natural gathering place. This had an impact on the delivery of some activities, as it was not always a calm and quiet space to support the activity work.

We also saw an area that had some safety pods in place, which promoted dignity for those who required to use them.

A major improvement for staff was the dedicated staff room away from the main part of the unit, which afforded them uninterrupted breaks and rest periods.

We found the garden area to be well maintained but were disappointed to note that there was smoking / vaping permitted in the garden area. Given that it is against the law to smoke or allow smoking within 15 metres of a hospital building in Scotland, we raised this with the senior leadership team on the day of the visit. We were told that a senior manager had joined a national group to look at ways to implement the smoking policy nationally. We advised that the Commission were aware of health boards who have managed to implement it successfully.

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.

Any other comments

The Commission found some key issues we have highlighted in the previous visit have not yet progressed. We were able to see areas of good practice which were in the initial stages of development and implementation by the new senior leadership in the unit, which we have included in this report. We also heard the unit was moving to another site in summer 2025 and that written communication has been sent to individuals and with families in relation to this. We would like to be kept informed of progress and offer support where appropriate, as we recognise the challenge in working to an action plan, whilst also planning to move to a more appropriate site.

Summary of recommendations

Recommendation 1:
Manager should ensure that one-to-one discussions between individuals and staff are documented consistently in the care records.

Recommendation 2:
Review and audit paper and electronic records to ensure they are accurate and minimise duplication.

Recommendation 3:
Managers should consider physiotherapy input to the unit to support individuals to use the gym.

Recommendation 4:
Manager should ensure that all key professionals are invited to attend the MDT meeting, that the proforma is fully completed, that the views of the individuals are incorporated, and the actions being taken to progress the delayed discharge of each person are recorded.

Recommendation 5:
Managers and medical staff must introduce an audit process to ensure that AWI Act processes are correctly followed, and legal documentation is completed appropriately.

Recommendation 6:
Managers should ensure that there is recording of activities being offered and those which are declined. This will encourage ongoing review of activities within the unit that are person-centred and meaningful for all.

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.

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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