Mental Welfare Commission for Scotland

Report on announced visit to:
Dudhope Young People's Inpatient Unit, 17 Dudhope Terrace, Dundee, DD3 6HH

Date of visit: 21 January 2025

Where we visited

Dudhope Young People's inpatient unit (YPU) is a mental health facility with 12 inpatient beds for young people, aged 12 to 18 years, who require a period of inpatient assessment and treatment.

It is a regional unit, primarily providing inpatient services for Tayside, Grampian, Highland, Orkney, Shetland and the Western Isles. There is also an agreement to take young people from other Scottish health boards when Skye House (Glasgow) and/or Melville Unit (Edinburgh) do not have beds available.

On the day of our visit, there were seven young people in the YPU, two were on home pass and there were three vacant beds.

We last visited this service in November 2023 on an unannounced visit and made a recommendation on ensuring nursing care plan reviews reflected the individuals' care goals and the recording of nursing care plan reviews was consistent across all care plans. The response we received from the service was that there were plans to implement a new review structure and guidance template.

On the day of this visit, we wanted to follow up on the previous recommendations and meet with young people, their relatives/carers and staff and hear their views and experiences of how care and treatment was being provided on the unit.

Who we met with

We met with, and reviewed the care of seven people, two who we met with in person and seven who we reviewed the care notes of. We also met/spoke with two relatives/carers.

We spoke with the service manager, the lead nurse, the senior nurse, the senior charge nurse, the consultant psychiatrist, consultant clinical psychologist, nursing staff, including the network nurse and teaching staff.

Commission visitors

Kathleen Liddell, social work officer

Gordon McNelis, nursing officer

Jenn McIntosh, student nurse

What people told us and what we found

The feedback from the young people we met was mainly positive. We were told by them that “staff listen to me” and staff were “nice and supportive”. Both young people commented that there was a good choice of activities to engage in, including therapeutic and skill building, as well as activity associated with their hobbies and interests.

The young people we spoke with provided positive feedback in relation to attending school, reporting that they liked going as teaching staff were supportive and they felt their educational needs were being met. One young person commented on the positive impact on having a therapet dog in the classroom environment, telling us that this supported them to feel “calm” in the classroom setting.

The young people told us that they had a key nurse and were offered one-to-one support from various members of the multidisciplinary team (MDT) on a regular basis. One young person was not aware of their care plan however, the other young person told us they had actively participated in the completion of their care plan.

Both young people told us that they attended MDT meetings on a fortnightly basis and found these meetings to be positive, adding that they felt able to provide their views in relation to their care, treatment and support; they felt involved in discussions and decision making regarding their care.

Both young people were aware of discharge planning, commenting that they were in agreement with the discharge plan.

Both were aware of their detained status however, commented that they were unaware of their rights and how to exercise them. We saw from review of the care records that they had access to advocacy support and legal representation and were pleased to see that they had been supported to exercise their rights.

Comments from relatives/carers

We spoke with two relatives/carers who provided mixed feedback regarding the care of their young person. We heard from one relative/carer that the care their young person was receiving was “excellent” and that "staff are very nice" and "accommodating".

Both relatives/carers commented that they were invited to attend regular MDT meetings and felt involved in most decisions made regarding the care and treatment of their young person.

One relative/carer commented that “communication was not consistent among all staff”, “my views are not always listened to” and raised concerns in relation to “poor discharge planning” that had had a negative impact on their young person and family. Relatives/carers raised concerns over decreased direct psychology input in

the YPU and the negative impact this had on the care, treatment and support of their young person.

The YPU had a carer support worker who offered relatives/carers a range of supports, for example, signposting to services, providing informative and emotional support which was welcomed by the carers/relatives. Relatives/carers we spoke with commented that the carer support worker was “an excellent support” and they felt “comfortable” speaking to them.

We spoke with staff on the day of the visit and they commented that there had been an increase in the complex presentations by young people, with multiple diagnosis and increased levels of acuity and “challenging behaviour” in the unit. We were told that there had been an increase in the number of incidents of violence and aggression towards staff which, at times, was difficult for staff to manage. Staff commented that the diverse range of diagnoses and presentations proved challenging for staff to consistently provide specialist care and treatment however, they felt that they had the knowledge and skills to provide the young people with specialist care.

We heard that training and skill development was promoted and encouraged to support staff to maintain and enhance the specialist skill set, and knowledge required to work in the YPU.

All staff spoken with were happy in their role, felt supported by the management team and were committed to providing the young people with high quality care, treatment and support.

Care, treatment, support, and participation

Nursing care plans are a tool which identify detailed plans of nursing care. Good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

We found the nursing care plans that we reviewed to be of good standard. The care plan template included background information, aims for admission, physical health care needs, rights and restrictions, discharge needs, and clear details on the purpose of the nursing intervention.

The information recorded in the care plan was comprehensive, strengths-based, and person-centred. The care plans adopted a holistic approach from the MDT, which promoted an understanding of the young person, their circumstances prior to the admission and a focus on future planning.

There was evidence of participation from the young people and their relatives/carers in the care plans. We were pleased to find that for young people who had specific communication needs, the MDT had adopted innovative ways to promote their

participation. The care plans we reviewed recorded the young persons' views, wishes, and preferences throughout, which promoted a strong sense of the young persons' voice being heard.

We saw that physical health care needs were being addressed and followed up appropriately by the speciality doctor.

Two of the young people in the YPU had delays in their discharge. We reviewed the care records for both and were satisfied that there was a proactive approach, and evidence of joint working between services, to support discharge. We heard of the concerns from relatives/carers concerns over discharge planning. On review of the care records, we found that the MDT were promoting and supporting discharge planning that included the young person, relatives/parents and community teams.

We were told that additional discharge planning meetings were arranged to discuss this, and the role of the network nurses were pivotal in liaising with community teams and relatives/carers during the discharge planning process. We discussed with the management team the concerns that had been raised with us in relation to discharge planning from relatives/carers. The management team agreed to consider what was causing anxieties for relatives/carers and what was further required to enable a more supportive discharge experience for the young people and their relatives/carers.

In addition to the nursing care plans, we saw that the individuals were subject to Care Programme Approach (CPA). CPA is a framework used to assess, manage and co-ordinate the care of people with a mental illness, including young people in child and adolescent mental health services (CAMHS). We found this paperwork to be of a high standard, promoted a MDT approach, involved the young person and their relative/carer, and was regularly reviewed.

We made a recommendation in the last visit report in relation to ensuring nursing care plan reviews reflected the individuals progress towards care goals recorded in the nursing care plan. We were pleased to find that improvements had been made to the review process with the introduction of a care plan review section. We saw regular reviews of care plans taking place that evidenced robust information, including summative evaluation regarding the efficacy of targeted nursing intervention, as well as the young persons' progress. We saw that young people and relatives/carers had participated in their reviews.

Care records

Information on the individuals' care and treatment was held in paper files and on the electronic system, EMIS, which we found easy to navigate.

In reviewing the care records, we were pleased with the level of comprehensive and individualised information recorded by all members of the MDT. It was evident from

our review of the care records that many of the young people in the YPU experienced high levels of stress and distress and required significant levels of support and intervention from the MDT on a regular basis.

The information recorded in the care records was person-centred, strengths-based, outcome and goal focussed and included forward planning. It was evident from reading the care records how the young people had spent their day, what members of the MDT had had interventions with them, and the outcome of interventions. We were pleased to note that the information recorded in the care records aligned with the care plan goals and outcomes. The care records were of a high quality and the comprehensive information promoted a holistic approach to the care of young people in the unit.

There was evidence of frequent one-to-one interactions between the young people and all members of the MDT. The young people we met with told us that they met with their key nurse and other members of the MDT regularly. The one-to-one interactions we found were comprehensive, personalised, and strengths-based.

We were pleased to find that the care records included regular communication with relatives/cares and relevant professionals, including community teams.

We reviewed risk assessments and found them to be of a good standard. There was a separate risk assessment that recorded comprehensive, clear and concise information on past and current risk. The risk assessment recorded protective factors, stressors and a risk/safety management plan that detailed how the risk should be managed and the interventions required. The care plans also included information on risk and risk/safety management.

The information in the care plan was condensed however endorsed essential information on risk and management of risk recorded in the substantive risk assessment. We saw regular reviews of the risk assessments, the views of the young people and their relatives/carers and changes made to the management plan to reflect either new or reduced risk.

Multidisciplinary team (MDT)

Care and treatment in Dudhope YPU was provided by the MDT which consisted of a full time and one part time consultant psychiatrist, a speciality doctor, nursing staff, occupational therapist (OT), dietitian, speech and language therapist, family therapist, two allied health professional assistant practitioners (AHP), and consultant clinical psychologist.

We heard that there were vacancies in physiotherapy, social work and clinical psychology, resulting in gaps in provision of these services to the young people in the unit. We were told that the post for the physiotherapist had been advertised.

In relation to the psychology post, we were told that there had been a delay in advertising it due to the recruitment process in NHS Tayside. We met with the consultant clinical psychologist on the day of the visit and were concerned to hear that the psychology provision in the YPU had been significantly reduced due to current vacancy (1.0WTE clinical psychologist) and the loss of previously borrowed time of an assistant psychologist. It was clear from the review of the care records the negative impact of this and the limited capacity to provide psychological interventions was having on the young people's care, support and treatment. We raised this as a concern to the senior management team who agreed that increased psychological input would be beneficial to the young person's care and treatment and they will continue to raise this with their senior managers.

Education for the young people took place in the onsite school. The YPU had a team of three teaching staff who provided education to the young people in the school environment and in the YPU, if required. We heard and saw that visiting teachers were arranged to support the young people's educational needs. The young people spoken with provided positive feedback about school and the importance of continued education input throughout their admission to the YPU.

During the last Commission visit, social work were part of the MDT. We heard that there had been no social worker in the MDT since June 2024 and as yet, the role had not been replaced. We were told that the service was reviewing the role of social work and consultation was taking place between the service and the host Health and Social Care Partnerships as to how the social work role could best be utilised to benefit the young people and their relatives/carers in the YPU. We heard that a pilot project trialling a 'link social worker' was under discussion with Aberdeen City Council. We look forward to hearing about the outcome of this project.

The MDT meetings were held weekly with young people being discussed on a fortnightly basis. The MDT met weekly in the unit, although Microsoft Teams was also used to host the MDT, which ensured greater participation and involvement from relatives/carers and external agencies. The young people and their relatives/carers were invited to attend the meeting if they wished. The MDT meeting template included a section for the young people to record their views if they did not wish to attend.

We found recording of the MDT to be mainly detailed, recording comprehensive updates from all members of the MDT on the young person's progress or areas of increased support where needed, as well as detailed discussion, decisions and outcomes on the young person's care, treatment and support planning. We saw evidence of discharge planning and involvement from community services to support discharge planning.

We were pleased to find active family participation in the MDT discussion and decision making. There was evidence of clear links between MDT discussions and care plan outcomes, as well as evidence that young people were making progress and moving towards achieving the aims and goals of the admission. It was clear that everyone in the MDT was involved in the care of the young people and committed to adopting a holistic approach to care and treatment.

Some of the MDT meetings we reviewed recorded less detail in relation to outcomes and decisions. We raised this with the management team on the day of the visit who suggested that this might be the case for our delayed discharge patients. The management team agreed that an audit of the MDT meetings would be undertaken as a priority.

We were pleased to be told that there is a dedicated link with the local child protection and adult support and protection team to discuss any child protection (CP) and/or adult support and protection concerns (ASPA). We were pleased to hear that staff from these teams offered 'supervision' to staff in the YPU in relation to any complex CP and ASPA cases.

Use of mental health and incapacity legislation

On the day of the visit, six young people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (AWI Act), including certificates around capacity to consent to treatment were stored electronically on EMIS and in paper files. We did not find this system easy to navigate and found that not all of the documentation in paper files correlated with information stored electronically, increasing the risk of staff not having essential and up-to-date mental health documentation. We raised this with senior managers on the day of visit who agreed to undertake an urgent audit of the paper files containing legal documentation.

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) and forms required for urgent medical treatment (T4) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a young patient over the age of 16 years had nominated a named person, we were able to locate all documentation relating to the person's detention on EMIS.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. One young person had a section 47 certificate in place with an accompanying treatment plan.

Rights and restrictions

Dudhope YPU operated a locked door policy at the time of the visit, commensurate with the level of risk identified with the patient group. When there is no requirement for locked access or egress to be in place, the unit is considered to be 'open', with only restrictions on egress from the ward area for purpose of child protection/safe-guarding.

Of the young people we met with, we found that they had a mixed understanding of their rights as a detained young person. On review of care records, we were pleased to find that many of the young people had access to legal representation and advocacy and had exercised their rights. Managers later confirmed that all young people have access to legal representation and advocacy.

We saw that staff were promoting rights in a variety of ways such as having information available on rights displayed around the YPU and also by adding a section on rights and restriction into the care plan template which was discussed and reviewed with the young people regularly. Nevertheless, the young people spoken with did not have a good understanding of their rights. The staff we spoke with recognised that the due to the levels of acuity and complexity of the young people in the YPU, ongoing proactive work was required to ensure promotion of rights. We were pleased to see and hear that advocacy was available to individuals in the YPU and was provided by Partners in Advocacy.

Some of the young people were engaging in the 'Rights Respecting School' award which was underpinned by UN Convention on the Rights of a Child (UNCRC) and promoted wellbeing, participation, relationships and self-esteem.

Dudhope YPU had regular community meetings. The meetings were run by members of the MDT with the purpose of offering a reflective space for young people to consider and discuss what was working well in the unit, as well as any areas of improvement that was needed.

We discussed restrictions with the young people we met. We were told by them that they did not feel restricted in the unit. We heard that young people were in agreement with pass arrangements and had consented to the restrictions in them accessing their mobile phones overnight.

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 found one advance statement on file. The young people we spoke with were aware of advance statements however, they had decided they did not want to complete one. We also saw good promotion of advance statements in the care plans, CPA and in the information on rights located in the unit on posters, leaflets and via QR codes.

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

The activity in Dudhope YPU was provided by variety of the MDT, community services and volunteers. We saw evidence of a range of activities that were available to the young people including music and art groups, therapet sessions, physiotherapy groups, groups run by AHP team, use of the gym for exercise, decider skills, relaxation, mindfulness, yoga, jigsaws and arts and crafts.

We heard and saw that some of the young people attended activities in the community, such as trips to the cinema and shops. We were pleased to see skill development opportunities being provided to some individuals, which supported the young person's future and discharge planning.

Activities were recorded in the young people's care plans and in addition, each young person had a personalised activity timetable that was person-centred to their own goals, outcomes, likes and interests.

We found all activity was recorded on EMIS by the MDT. The records reviewed were of a high quality, personalised and provided comprehensive information on the purpose and goal of the activity, how the young person presented during the activity and future planning.

All young people were encouraged to attend the on-site school. We visited the school and saw that young people in attendance were being supported by teaching staff to engage in work in accordance with their stage of education; we observed them looking happy, calm and content whilst at school.

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

The physical environment

The unit is purpose built with the residential unit on the first floor. The reception area was very welcoming and promoted artwork completed by the young people, as well as a new coffee machine that young people, relatives/carers and all visitors could use.

The unit was clean, bright and welcoming, with extensive artwork, sensory and soft furnishings. We were particularly impressed with the photographs displayed on the walls of the corridors of the local areas where young people came from, to promote them feeling connected to their home.

All bedrooms were en-suite. We viewed some bedrooms and saw that they had been personalised**.**

There was a large gym in the unit that could be used for basketball, yoga and rebound therapy. This YPU had a sensory room that young people used for therapeutic interventions and relaxation.

The unit had a variety of sitting rooms and communal spaces that the young people could use. We were disappointed to hear that some of the areas in the building had no heating resulting in the young people not being able to use these areas. We also saw and heard that the lift to the residential unit had been out of order for over a year. We heard from staff and young people that this had negatively impacted on contact with family where there were mobility needs and when young people were experiencing high levels of stress and distress on the ground floor and required support to get to safe space in the residential unit. We heard from the management team that the heating and lift issues had been reported to estates for repair however, we were concerned to be told there had been no progress in the issues being resolved.

Recommendation 1:
Managers must prioritise addressing the outstanding environmental issues in relation to maintenance to ensure the environment is safe and all areas are available for the young people to access.

There was a secure garden space in the courtyard of the building that the young people could access. The ‘Bluebell Bothy’, a summer house was particularly popular with the young people as it was a private space in the garden that they could use.

The unit provided accommodation for families to visit their loved ones. This is an important resource that is used to promote contact with family and support discharge planning. The flat was out of use during the last visit, although we were pleased to see that that flat had been repaired and was back in use.

Summary of recommendations

Recommendation 1:
Managers must prioritise addressing the outstanding environmental issues in relation to maintenance to ensure the environment is safe and all areas are available for the young people to access.

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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