Mental Welfare Commission for Scotland

Report on announced visit to: Daleview Ward, Lynebank Hospital, Halbeath Road, Dunfermline KY11 8JH

Date of visit: 9 December 2019

Where we visited

Daleview Ward is a 10-bedded, regional low secure forensic unit which is situated in the grounds of Lynebank Hospital, Dunfermline, Fife. It accommodates patients with a diagnosis of learning disability and those that have come into contact with the criminal justice system. Daleview Ward is a male-only ward and admits patients over the age of 18 years with no upper age limit. It is a locked facility. Daleview is able to offer this resource to NHS boards and partnerships across the east of the country including Grampian, Lothian, Forth Valley, and Borders. The unit was purpose built and has a reception space, large communal areas, and en-suite bedrooms. It is a modern space and is well-presented.

We last visited this service on 28 August 2017 and made no recommendations.

On the day of this visit we wanted to meet with patients and look at care and treatment, physical health care, patient rights in relation to any restrictions, and the underlying reasons for delays in discharge. These are similar themes to our previous visit but we are aware that they remain pertinent.

Who we met with

We met with and/or reviewed the care and treatment of eight patients and also met with relatives of one patient on the day of our visit.

We also spoke with the lead nurse, senior charge nurse (SCN), and the senior occupational therapist who provides input to the ward. We also met a range of nursing staff throughout the day.

An individual session also took place with a representative of the local advocacy service in West Fife. She advised that there is a link advocacy worker attached to the ward and relationships in general are positive between professionals, patients, and the service. Nearly all patients on Daleview are represented by advocacy services, and those that are not have made a choice not to do so. The advocacy service has recently provided an awareness-raising session for staff in relation to their role and rights based practice. This was well-received and plans are in place to develop further sessions.

The advocacy representative further advised that the main issues being raised by individual patients are length of stay in the ward and the fact that discharge can be delayed.

Commission visitors

Paula John, Social Work Officer

Claire Lamza, Nursing Officer

Phillip Grieve, Nursing officer

What people told us and what we found

Care, treatment, support and participation

We spoke with eight patients on the day of our visit and reviewed all 10 care plans. The majority of patients told us that they had good relationships with nursing staff and other members of the clinical team. We were also able to observe these interactions. Some added that they would like to see more of their doctor and, where possible, be able to spend more time off the ward. In addition, some patients added that they felt they had been in hospital for a long time and were keen to move on from the Daleview Unit. In relation to these discussions, we advised patients to raise issues with their clinical team members with the assistance of advocacy staff in the first instance.

We spoke to two family members who wished to raise some points in relation to medication, communication, and placement. However, in general they were likewise positive and felt that the care and treatment being offered to their family member was of a good standard.

A pressing issue for both staff and patients was the matter of delayed discharge which has been a significant issue for the majority of patients within this ward. We raised this with senior management staff on the day. This is a complex issue and involves work around risk management, ensuring this is right both for individuals and the wider public, securing appropriate housing, and the commissioning of social care staff to provide support. Managers advised that there is a strategic discharge planning meeting in place for the hospital that has an overview on the progress of each patient. This is attended by health, social work, and housing staff and has been effective in achieving good outcomes. We were advised that two patients currently in Daleview have plans to move on in January 2020 and we would want to be informed of any delays.

The Daleview Unit has a strong multidisciplinary team (MDT) including nursing, psychiatry, psychology, speech and language therapy, pharmacy and art therapy. There is also availability to refer individual patients to podiatry, physiotherapy, dentistry, and a dietician. This holistic approach was evidenced in the care plans and there was good input noted in relation to physical health care. All patients had a passport to health in place and physical health care reviews were taking place.

We were advised that not all staff are able to provide psycho- social interventions but both the lead nurse and the SCN, who has recently been appointed to the ward, have plans to develop this area. This will also include looking at a formalised clinical supervision structure for all staff. Currently, philosophy of care meetings take place which involve the MDT reviewing individual care plans for patients and seeking to improve these. We were advised that staff would be keen to have more peer reviews of this nature in the future, with the aim of further developing the service.

MDT meetings take place weekly and decisions and outcomes are clearly recorded. There was less evidence of patient participation, but advocacy services regularly attend the ward and patient's views are incorporated well. The consultant forensic psychiatrist for the unit is employed three days a week and some patients commented that they would like more contact with their doctor. However, we did find evidence of regular medical review within care plans.

The enhanced Care Programme Approach (CPA) is used for all patients on the ward, this being a more formalised case management system with individual plans and a case co-ordinator being in place. Minutes were on record and were detailed with the case co-ordinators identified and action plans in place.

We also looked at care plans and found these accessible and well organised. They were highly personalised and related well to the goals and objectives of each patient's care. Risk assessments and positive behaviour support plans were also on record and were being regularly reviewed. More attention could have been paid to the review process, by analysing the plans and detailing any potential for change.

We thought that the standardised paperwork developed for the service was particularly helpful in contributing to background information on patients and the specific details of delivering care and treatment, for example the initial assessment form and the weekly recording sheet.

The Commission has published a good practice guide on care plans. 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, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Use of mental health and incapacity legislation

We were able to locate the relevant paperwork for those patients that were subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') and in the main this was completed appropriately.

There were some issues with specified persons paperwork which authorise restrictions around the use of phones and correspondence. The reasoned opinion that requires to be clearly identified as to why this practice has been determined was not always obvious in notes. We would suggest that there is reviewed and addressed. We did note good practice that the decision to apply specified measures was done on an individual basis and was not a blanket policy for the unit.

Where relevant, copies of welfare proxies' guardianship orders and powers of attorney under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') were also found within records.

In addition, we found two issues with certificates to authorise treatment (T3s) under the Mental Health Act. These authorise medical treatment where an individual is not able to consent. We addressed this with staff on the day and they were able to deal with it promptly. We were advised that there is pharmacy input to the ward to assist with these issues.

We also found that section 47 paperwork under the AWI Act was in place and there were no issues.

Recommendation 1:

Managers should ensure that a system is in place for consistent completion of specified persons paperwork, particularly in relation to reasoned opinions.

Rights and restrictions

Daleview as a secure facility has a locked door at the main entrance, reception area, and internally where double doors separate the clinical areas from staff and meeting rooms. There is a locked door policy in place and the security is in place for the welfare and protection of patients. All patients are subject to compulsory measures, but access to and from the ward is individually care planned for. We were advised by nursing staff that this is managed following risk assessment with the aim that all patients are able to spend time off the ward and work towards independence. This work is usually carried out with a nursing escort.

As highlighted earlier, advocacy services are regular visitors to the ward and staff here were able to confirm that patients are informed and know of their rights. We did note some gaps in rights based care; for example, information on named persons and a minimal number of advance statements, but this did not apply to all patients.

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Activity and occupation

Regular activities are taking place with patients and these are undertaken by both nursing and OT staff. Activities involve both group and individual sessions and we were able to observe some low level one to one activities taking place on the day. There is an OT dedicated to the ward who assists in both individual planning and undertaking functional assessments. Each patient had an activity timetable contained within their case records and these provided good information. Some could have been more detailed, and we suggest a record of activities offered and refused would also be helpful.

Despite this, we did get some feedback from patients that they were bored and would like more options in relation to activities. Senior staff emphasised that they are keen to pursue activities and work placements off the ward and locally. This has proven to be a challenge of late and they are continuing to pursue these.

The physical environment

Daleview Ward impresses as a relatively new building and environmentally looks well maintained and fit for purpose.

Daleview is a large building and has a reception area, clinical and living areas, and a separate staff area incorporating meeting and interview rooms. The SCN advised that more use could be made of the large reception area and she had plans in place to make this more welcoming for visitors, particularly family members. Factors such as a range of literature and information on the ward was also lacking and this was another area she hoped to rectify.

The ward itself is a long building opening onto a nursing station placed at one end. There is also a dining space, living space, and a sensory room. All bedrooms are single rooms and have en-suite facilities. The overall impression was somewhat cold and clinical, although some of the individual rooms were personalised with pictures and private belongings. Again, the SCN advised that there had been some changes made to the positioning of the nursing station which has reduced congregation of staff and patients. She also hopes to improve the environment with small and appropriate changes to give it a warmer, lived-in atmosphere. We are aware of the constraints given the nature of Daleview itself, but look forward to seeing these on our next visit.

Other issues

From our discussions with the lead nurse and SCN, we gather that with new staffing appointments the service is looking to change aspects of its working ethos, particularly in relation to developing staff training and supervision, and focusing on a more trauma informed model of practice. The issue of past trauma is something that has been identified in the unit for the last number of years and the aim is that a more holistic, psychological approach can be developed and spread across the MDT.

The service is also mindful of any recommendations and comments that will come out of the current Forensic Review.

We look forward to seeing the outcomes of these proposed changes on our next visit.

Summary of recommendations

1. Managers should ensure that a system is in place for consistent completion of specified persons paperwork, particularly in relation to reasoned opinions.

Service response to recommendations

The Commission requires a response to this recommendation 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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