Mental Welfare Commission for Scotland

Report on announced visit to:

Mayfield Ward, Lynebank Hospital, Halbeath Road, Dunfermline KY11 8JH

Date of visit: 20 April 2023

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Mayfield Ward is an assessment and admission ward that is situated in the grounds of Lynebank Hospital, Dunfermline, Fife. It is a 13-bedded, mixed-sex ward and admits patients over the age of 18 years with no upper age limit; the ward has been designed for adults with learning disability and autism.

We last visited this service on 24 September 2019 and made recommendations in relation to discharge planning, accurate completion of section 47 certificates to include accompanying treatment plans and, improving privacy for patients who wished to use the ward's garden.

On the day of this visit, we wanted to follow up on the previous recommendations and to hear how patients and staff have managed throughout the pandemic. This is because we were aware patients in Mayfield Ward had access to community recreational resources and attending community activities was often very important to them. We heard that with restrictions all but eased completely; this has enabled patients and staff to venture away from the ward and opportunities to socialise with patients from other wards on the hospital site. This has been welcomed by patients who enjoy the social aspects of seeing their peers.

Who we met with

We met with, and reviewed the care of six patients, four who we met with in person. We also spoke with two relatives.

We spoke with the service manager, the senior charge nurse, the lead nurse, consultant psychiatrist and nursing staff including keyworkers.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

On the day of this visit, patients were keen to tell us how much they enjoyed the company of staff, and that they appreciated the various activities available to them and felt safe. This was important to them as patients recognise feeling safe and listened to helps them to feel relaxed and engaging in therapeutic activities with staff builds confidence. Relatives were equally positive with their views of Mayfield Ward. We heard phrases such as "the staff are brilliant" "our family feel listened to; we are involved in our son's care and staff communicate with us to make sure we remain involved". This was clearly important for families as their family member may have been in hospital for a considerable period and maintaining relationships was essential for future transition planning from hospital-based care to community.

Care, treatment, support and participation

On the day of this visit, there were seven patients, all of whom required a high level of support from nursing staff. This is because patients in Mayfield Ward can often present with behaviours that challenge. Nursing staff in Mayfield Ward have had additional training and are skilled to work with patients to ensure care and treatment is individualised and person-centred. Each patient benefitted from a multi-disciplinary team (MDT) model of care with input provided by medical staff, nursing, psychology, occupational therapy, speech and language therapy and referrals to other allied health professionals as required. Patients also benefitted from the training staff have had in relation to positive behaviour support (PBS). PBS is a model that encourages the MDT to assess each patient's presentation for example, consideration is given to the environment, relationships, physical and mental well-being, and any areas where the patient may experience difficulties and in turn display behaviours that challenge. To support a whole team model of care and treatment, each patient had an additional team formulation. Psychological formulations are beneficial for the patient and staff as they provide an understanding of presentation and behaviours. Relatives told us they had observed a significant improvement in their family member's behaviour, with staff identifying triggers and putting in place support strategies to reduce anxiety and stress.

Care records

Patients' care records were held on electronic record system 'Morse'. This was a new system for staff however, we were told they had found the transition from paper to electronic record keeping straightforward. In the daily continuation notes we would like to have seen a more detailed narrative. We were aware nursing staff spent a considerable amount of their day engaging with patients, particularly those who required enhanced observation. We would therefore have expected to see a subjective and objective view of how patients and staff interacted, the interventions that had gone well or when a patient was stressed and how staff supported the patient to feel calm again. The richness of any narrative allows the reader to fully appreciate the care and treatment provided by staff and how this benefits patients. We discussed evidencing interventions and engagement with the leadership team and wondered whether having a system in place that allowed staff to consistently document the views of patients, while evidencing observations from staff would enhance continuation notes.

Recommendation 1:

Managers should consider identifying a system that captures daily contact between staff and patients in their electronic care record.

We also looked at care plans and found consistent evidence of individualised, person-centred and personalised care plans. We were impressed to see additional evidence of PBS being included for each patient who required interventions to reduce behaviours that challenged. We recognised that for some patients, identifying their own specific needs would be difficult. However, we would like to have seen considerations for individuals' strengths and less of a deficit perspective, as we were told this was important to patients and their families.

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/node/1203

We were keen to review patients who were subject to enhanced observation and patients who required periods of seclusion. This is because we published our *Use of Seclusion* good practice guide in 2019. Seclusion_GoodPracticeGuide_20191010.pdf.

We were told several patients required periods of time in their rooms. While there were staff available to support them if required, there were also times where a patient needed time alone. When reviewing seclusion documentation, we could identify times where patients were kept in their bedroom, and this was attributable to reduced numbers of staff availability. We were informed by the service that staffing resources had remained an issue for a considerable period and while there were core members of the team, there were times where shifts were supplemented with bank and agency staff. There was a recognition that for patients, this could be difficult however, the priority was safety and wellbeing. Therefore, where a patient was displaying behaviours that challenge, a period of seclusion may be necessary. This situation was closely monitored by the service, who remained committed to improving staffing resources. All periods of seclusion were included in the Fife Health and Social Care Partnership incident reporting system and discussed in the MDT meetings.

During this visit to Mayfield Ward, we were once again informed there were patients who had been in the ward for a considerable period and this was a source of frustration for them, their families, and staff. We were told all patients were considered to have their discharges delayed from hospital when they were deemed ready to move on from hospital-based care. However, allocating placements in a community setting continued to be fraught with difficulties. Relatives told us that while they have welcomed the ward's care and treatment, they would prefer their relative to live in the community and have opportunities to live in their own tenancy or a supported group home with peers. We were told by the service of the difficulties encountered when finding suitable and appropriate placements and arranging a package of care that met the specific needs of individuals. Where there had been discharges from hospital-based care, this had been successful due to appropriate placement, support staff having the right skills to work with individuals, and an intensive transition period to enable a sustainable discharge. Unfortunately, for the current patients, there were limited opportunities for those resources although the service has endeavoured to work with their local authority partners to enable transfers of care from hospital to community settings. We were keen to receive updates from the service, as we were told there would be some progress with patients moving on in the coming months.

Use of mental health and incapacity legislation

On the day of our visit, all patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or Criminal Procedure (Scotland) Act 1995. We were able to locate the relevant paperwork for those subject to compulsory measures.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. We found an issue with one T3 certificate to authorise treatment under the Mental Health Act. We addressed this issue with staff on the day and they were able to deal with this promptly. We were informed that there was pharmacy input to the ward to assist with governance around authorising treatment.

Where patients had a welfare guardian, we were able to locate relevant copies of welfare proxy's guardianship orders and powers of attorney under Adults with Incapacity (Scotland) Act 2000 (AWIA).

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWIA 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. We found issues with s47 paperwork, and highlighted this as a concern on the day. However, given that we found similar issues on our last visit to the ward, we are repeating our last recommendation and urge the senior leadership team to consider identifying a knowledge and training action plan for the ward-based team to ensure AWIA paperwork is accurately completed.

aRecommendation 2:
Managers should ensure that a system is in place to ensure consistent completion of s47 paperwork and accompanying treatment plans where required.

Rights and restrictions

Mayfield Ward had locked doors at both the main entrance and internally, where double doors separated the clinical areas from staff and interview rooms. There was a locked door policy in place and the security was in place for the welfare and protection of patients. Where possible, staff took opportunities to escort patients out of the ward. It was recognised that some patients benefitted from visiting their peers in other wards or taking opportunities to visit family. For some patients they retained contact with their community support services and enjoyed maintaining therapeutic relationships or getting to know their new support staff during the period of transition from hospital-based care to living in their new home.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction be applied. Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place.

We were advised that advocacy services were regular visitors to the ward and patients were informed of their rights. The ward had identified there were some gaps in relation to supporting patients with their understanding of rights-based care. We were pleased to see patients were provided with 'easy read' or illustrations / pictures to help them understand their rights.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We were aware that during the Covid-19 pandemic, restrictions that were put in place had meant that various activities out with the unit had to be put on hold, and that some of the patient group had struggled with this change to their routine. However, we heard about the efforts of nursing staff to ensure there was always activity available on the ward for patients. For patients in Mayfield Ward, there had been a significant effort to engage in fundraising opportunities. We were told by patients that getting creative, and promoting their arts and crafts was an exciting venture and the feedback received from staff and visitors had been very positive. Patients and staff valued the work undertaken by the occupational therapist (OT) and the OT assistant; this was because there was a recognition that functional assessments and therapeutic engagement were essential for learning new skills and promoting patient's sense of well-being and acceptance.

Where patients were unable to join their peers for social and recreational sessions, there were opportunities for one-to-one work. With recreational and therapeutic engagement very much at the centre of the care and treatment model in Mayfield Ward, there was a sense patients were given opportunities to engage in activities that they choose and were able to find a connection with.

The physical environment

Mayfield Ward was a large building with several clinical rooms, separate space for visitors and 'pods' that allow for patients to have their own space. Mayfield Ward had seven patients, and each patient had their own room, with some patients having their own suite of rooms. This was important to them, as sharing social spaces with their peers could be stressful. Patients had access to two dining rooms and sitting rooms where socialising could take place. The ward was bright, well maintained, and modern. The central hub of the ward was rather 'echoey' and there had been attempts to reduce sound, as it was recognised for some patents in Mayfield Ward, sound could be distressing. There was a therapeutic kitchen in the ward, which allowed patients to learn and maintain cooking skills and food preparation.

There was outdoor space for patients to use. The garden had attractive plants and shrubs while offering various seating options. We were told that although there was an advantage to having an attractive outdoor space, there was however a lack of privacy due to the housing development adjacent to the garden. We were told the lack of privacy was likely to be the cause of patients to not utilise the outdoor space, even in the summer months. During our previous visit to Mayfield Ward, we identified this as a concern, as it was felt to compromise

patient's safety, privacy and dignity. We were therefore disappointed to find the garden area had not been provided with privacy screening and discussed this with the leadership team on the day of the visit.

Recommendation 3:
Managers should improve the privacy for patients in the garden area; this should be considered as essential to promote safety, privacy and dignity for all patients and staff.

Any other comments

We were aware of the challenges to finding suitable accommodation and placements for patients in Mayfield Ward. Staff recognised the ward provided patients with safety, and with opportunities to develop new skills and provided encouragement to live a life with a degree of independence. However, it could be difficult for patients to think about the future when there was a dearth of suitable accommodation or where packages of care were problematic to arrange due to funding or resource issues. This was a source of ongoing frustration for patients, their families and the multidisciplinary team. However, while patients continued to wait for their transition from hospital-based care to future placements, it was important to recognise the ward-based team were making every effort to maintain enthusiasm and motivation for all the patients in their care.

Summary of recommendations

Recommendation 1:
Managers should consider identifying a system that captures daily contact between staff and patients in their electronic care record.

Recommendation 2:
Managers should ensure that a system is in place to ensure consistent completion of s47 paperwork and accompanying treatment plans where required.

Recommendation 3:
Managers should improve the privacy for patients in the garden area; this should be considered as essential to promote safety, privacy and dignity for all patients and staff.

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.

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 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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