Mental Welfare Commission for Scotland

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

Date of visit: 25 May 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 that is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Daleview Ward is a 10-bedded regional low secure forensic unit that is situated in the grounds of Lynebank Hospital. It accommodates patients with a diagnosis of learning disability and those that have come into contact with the criminal justice system. Daleview Ward is male only and admits patients over the age of 18 years, with no upper age limit. As the East of Scotland facility, it is able to offer this resource to several health boards across Scotland including Highland, Lothian, Forth Valley, Borders and Fife. This unit was purpose-built and has a large reception area, several communal areas and all 10 bedrooms have en-suite facilities.

Who we met with

Of the seven patients currently cared for in Daleview Ward we had the opportunity to meet with six patients and reviewed their care records. We spoke with the service manager, the senior charge nurse, the lead nurse, advocacy, and several members of the nursing team.

Commission visitors

Anne Buchanan nursing officer

Arun Chopra, executive director (medical)

Tracey Ferguson, social work officer

Gordon McNelis, nursing officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit, the ward was calm with patients and staff engaging in activities, either in small groups or with one-to-one therapy. Interactions between staff and patients were observed to be kind, thoughtful and staff were knowledgeable about their patients. Patients were keen to show us the improvements that had been made to the ward since our last visit. The 'hub' that had previously been situated in the central part of the ward had been removed and replaced with comfortable seating that invited patients and staff to socialise together. Patients were also keen to show us their impressive charity work undertaken to improve the lives of others in their local community. This was clearly important to everyone, including staff who told us how proud they were of their patients and the determination they had shown to support their chosen charities.

Patients we met with were positive about their experiences in Daleview Ward. We were told "staff go out of their way to help you". For some patients we heard how important it was for them to have a sense of safety and well-being, and having staff available to them when they were feeling upset. We heard from patients that staff were approachable, they felt listened to and were supported throughout their stay in Daleview Ward. We were also told of a patient's experience of having to wait for discharge from hospital to community, which we heard was extremely frustrating. Furthermore, on discharge, there was the possibility of not returning to their own community or a setting they would not have chosen; this was likely to make the transition more difficult. However, patients told us they did feel supported with transitions from hospital to community by psychology, occupational therapy and the wider multi-disciplinary team. Patients were keen to show us their individualised discharge pathway illustrations also known as 'road to freedom'. With support from the occupational therapist, psychology and nursing keyworkers, each patient had a diagram of their pathway to discharge on their bedroom wall. In their personal diagrams, there were illustrations to recognise a patient's strengths, what needed to be in place to enable recovery, and who would be needed to support the patient and help them during their rehabilitation. Patients we spoke to told us they had ownership of their pathway to discharge and felt involved in making decisions to enable this to happen.

This was further extended to supporting patients to engage with the 'Good Lives Model', an approach which provided opportunities for each patient to consider what was important to them, that had the option to include health and well-being, relationships, learning new skills and stable mental health. Each patient had care plans that were person-centred and these recorded extensive input from the patient and members of the multi-disciplinary team. This personalised model of care and treatment lent itself well to engaging with patients, who by virtue of their early life experiences, or experiences in secure settings, had difficulties with attachment and trust.

We heard from advocacy services about recent improvements to enable patients to fully engage with their care programme approach (CPA) review meetings. CPA is a framework used to plan and co-ordinate mental health care and treatment. There was a recognition that CPA reviews should be person-centred, and every patient should have the opportunity for meaningful engagement with the review. However, for most patients this had been difficult,

as having a sense of being involved with discussions, goals and plans had previously not always been accessible to them. With input from psychology and speech and language therapy, the CPA had become a collaborative process with patients included in every discussion, decision and provided with 'easy read' documentation to ensure they were fully immersed in their CPA.

Multidisciplinary team (MDT)

Daleview Ward had a broad range of staff providing input for each patient, including nursing staff, a consultant psychiatrist, occupational therapy (OT), psychology, art therapy and until recently, speech and language therapy. For patients who required additional support from other allied health professionals, referrals were made to specific services. Each member of the MDT delivered care and treatment specific to their expertise and provided weekly feedback to the clinical team, outlining patients' progress. We were told by nursing staff they had received additional training to enhance their nursing skills. This included a more focused psychological approach when working with patients who had experienced trauma. Patients had regular input from psychology, and there was an emphasis on psychological formulations. Psychological formulations were helpful for both patients and staff, as they provided an understanding of each individual's presentation and behaviours.

We were told there would be further training available for nursing staff to attend courses specifically related to working with patients in the development of positive behaviour support (PBS) plans. Nursing staff were keen to develop their skills to ensure that patients were provided with care that offered safety and stabilisation.

Care records

Recently patients' records had moved from paper files to 'Morse', an electronic system for recordkeeping. While we found Morse easy to navigate, although we were told by staff that some records had been difficult to migrate over from one system to the other. However, staff had regular communication with Fife IT services to highlight any issues in order for them to be resolved quickly. In the electronic and paper files we found that the documentation clearly set out various assessments relating to patients physical and mental well-being; these were completed, reviewed and updated where necessary.

Throughout patient records we saw evidence of a collaborative approach to care and treatment that included all members of the MDT working alongside every patient and provided information that was accessible and straightforward. To ensure participation and supported decision making, nurses should be able to evidence how they have made efforts to achieve this and care plans should record actions and goals that are clear and attainable. Having reviewed a number of care plans we were pleased to see they were consistently of a high standard. Each patient's care plans related to their specific areas of need, with evidence of discussion between the patient and their keyworker to set goals and objectives. Furthermore, of the needs and goals identified, there was evidence of which member of the MDT would be supporting the patient to enable progress. Care plans were regularly reviewed, amended as necessary and we were told by patients they felt included with setting their own objectives to enable recovery.

Use of mental health and incapacity legislation

On the day of our visit all patients were subject to either the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or Criminal Procedure (Scotland) Act 1995 (Criminal Procedures Act) legislation. All documentation relating to the Mental Health Act and Criminal Procedures Act was available in the patient's electronic files.

Most of the patients we met with during our visit had some understanding of their detained status, where they were subject to detention under the Mental Health or Criminal Procedures Act. Of the patients we spoke with who had limited understanding around specific areas of their detention, we asked staff to ensure those patients were provided with 'easy read' documentation and opportunities to discuss their detention with keyworkers and medical staff.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place.

Where a patient was subject to Adults with Incapacity (Scotland) Act 2000 (AWI Act) legislation we were easily able to locate relevant paperwork, including copies of welfare proxies' guardianship orders. Where a patient 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. We were able to locate s47 certificates and the accompanying treatment plans in each patient's files and prescription charts.

Where there was a guardianship order under the AWI Act, patients also knew what this meant for them. Again, for patients who required additional information in an easy read format, we would encourage staff to provide this.

Rights and restrictions

Daleview Ward was locked and there was a locked door policy in place that was commensurate with the level of risk being managed in this low secure unit. Each patient had their own detailed escort plan and we noted that there were a number of patients who required their time away from the ward to be supervised. We were pleased to see escort plans that were reviewed regularly by the MDT, and amended when required, to reduce unnecessary restrictive practices. We were able to locate Mental Health Act paperwork authorising absence from the ward, with regular updates as needed.

All patients had access to legal representation and local advocacy services. Advocacy were in regular contact with individual patients and offered support and guidance for patients during Mental Health Tribunal for Scotland hearings. We heard from advocacy staff that in Daleview Ward, patients were encouraged to engage with advocacy staff and they were made to feel very welcome during visits to the ward. Furthermore, there were several patients who had regular input from their own 'citizen advocate'. A citizen advocate is matched with a patient and will provide input and also sometimes social contact and well-being. The relationship between the patient and advocate can last for as long as necessary, and there are patients who have had their own citizen advocate for many years. This continuing relationship

had its foundations built on trust and we were told by advocacy and patients that it was extremely important, particularly to those patients who had experienced adversity in their formative years.

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 is applied. Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place.

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

There were several therapeutic and recreational activities taking place on the day of our visit. Each patient had a weekly timetable and met regularly with their nursing keyworker to discuss progress. The ward-based OT undertook functional assessments, while also working with patients in the well-equipped therapeutic kitchen. We observed patients enjoying activities in small groups and supported by nursing staff during one-to-one work, while also engaging in lower-level recreational hobbies, such as outdoor sports in the ward's garden.

There was an art and craft room, along with a TV room, that offered patients opportunities for gaming, socialising, or using keep fit equipment. Nursing staff informed us there was an emphasis on physical health and this included healthy eating plans and physical activity. Physical health was monitored and included in the ward's 'good lives model' of care.

The communal area in the ward had been updated and offered opportunities for patients and staff to sit together and socialise. While there were activities available, patients told us they often felt bored during the day, if activities had to be cancelled or were not available on that day. This level of boredom experienced was often a source of frustration and patients felt their days were long and at times unfulfilled. The ward did not have a dedicated activities coordinator, and patients we spoke to felt having a member of staff who was able to invest time and energy specifically for activities would be welcomed.

Recommendation 1:
Managers should consider the addition of an activity coordinator to the ward-based team, to support patients and develop a consistent programme of recreational and therapeutic activities.

The physical environment

Daleview Ward was a bright, well-maintained, and welcoming environment. Each patient had their own bedroom with en-suite facilities. Patients were encouraged to personalise their bedrooms, adapt their space to ensure it provided a sense of well-being. Patients had their discharge pathway illustrations on their walls and pictorial strategies to help reduce anxiety, stress, and distress. Patients were keen to show us their bedrooms, and told us they were

given opportunities to invest in their personal space and they had found this beneficial and rewarding. The communal areas of the ward were bright and inviting, the dining room looked fresh with its new furniture and patients were keen to tell us that it was very comfortable. The ward benefitted from accessible outdoor space however, one of the gardens had been deemed not appropriate due to the proximity of a new housing development. We asked whether there was a possibility of adapting the garden to include appropriate screening, and were told this was under review, with considerations for funding being discussed. We asked to be updated as we were aware patients enjoyed accessing outdoor space and having opportunities to use all available space would be welcomed.

Any other comments

We had the opportunity to meet with members of the ward-based team, advocacy, and several patients. It was clear from our conversations there was a commitment from the team to ensure patient's voices were heard, their views and opinions in relation to their care was always at the forefront of patient care. Patients felt safe and were encouraged to be active participants in their care planning, which was evidenced in the new approach to CPA reviews. We appreciate there were concerns in relation to the ward currently not having a full complement of nursing staff. However, we were pleased to see patient care had not been compromised and initiatives to improve patient's experiences remained a priority.

Summary of recommendations

Recommendation 1:
Managers should consider the addition of an activity coordinator to the ward-based team, to support patients and develop a consistent programme of recreational and therapeutic activities.

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.

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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