Mental Welfare Commission for Scotland

Report on announced visit to:

Cygnet Wallace Hospital, 119 Americanmuir Road, Dundee, DD3 9AG

Date of visit: 6 November 2023

Where we visited

Cygnet Wallace Hospital is an independent service that provides specialist high-dependency complex care, in the assessment and treatment of individuals with learning disabilities, with or without autistic spectrum disorder, as well as complex needs and behaviours. Cygnet Wallace Hospital mixed-sex environment, currently registered for 10 adults.

We last visited this service in February 2023 as part of a themed visit; there were no specific recommendations for the service. Prior to that, we visited in November 2019 and made recommendations about care planning, linking the daily record of risk to the care plans, the delivery of training in Makaton for staff, specified persons documentation and refurbishment of the environment.

On the day of this visit we wanted to meet with those individuals who could describe their care experience in the hospital, to review their care and treatment, and to look at how the previous recommendations had been actioned.

Who we met with

We met with four individuals, and reviewed the care records of five patients. We also spoke with one relative after the visit had taken place.

We had a virtual meeting with the hospital manager, the deputy manager and one of the consultant psychiatrists prior to the visit. On the day, we met, in person the hospital manager, the deputy manager, both consultant psychiatrists, the speech and language therapist (SLT), the occupational therapist, and members of nursing and support staff.

Commission visitors

Claire Lamza, executive director (nursing)

Paula John, social work officer

Dr Margaret White, ST6 on placement at the Commission

What people told us and what we found

Of the 10 individuals in Cygnet Wallace Hospital, only five were able to communicate with us to provide their views of their care and treatment. On the day of the visit, we were able to meet with four people; the fifth person had recently been admitted and was still becoming used to the environment.

We heard mainly positive comments about day-to-day life in the hospital. We were told support from staff had helped individuals to become more independent, to cope with some of their problems and that staff were "good". Some people said that they felt safe in the unit and that moving to the hospital had been better for them than the service they were in before the transfer to Cygnet Wallace Hospital. We heard that for some "being here has really helped me to become calm"; for another it had helped them with "being able to talk and visit my family". We heard from people that they liked their doctors, that they were told what was happening and that they were able to do things they liked to do. When we spoke with the relative, they told us that they felt at times, there was a shortage of staff and that turnover in the staff group had been high, although in the last couple of years, there had been an improvement in this, and in communication with family members.

We did hear from some that it could be noisy in the unit, and that this could be a "trigger" for them. Some people said to us that at times, there weren't enough staff, in particular the member of staff that was to be available for any impromptu or unplanned requests, who patients referred to as the floater for the shift. We were told that often, with the level of observations that were needed, staff were not easily accessible and we heard that "it's not fair to those of us that aren't on obs".

When we spoke with the extended team, we heard that since our visit in 2019, there had been significant changes with staffing. There had been changes with the senior management team, and vacancies had been recently recruited to, that meant that agency usage had reduced. There were registered nurses for mental health and learning disabilities working in Cygnet Wallace, and a senior support worker rostered for each shift. We also heard that one of the consultants had recently been recognised for their commitment to medical training and teaching of multidisciplinary colleagues, having won an award as Educator of the Year for Cygnet Healthcare.

Care, treatment, support and participation

On our last visit to Cygnet Wallace Hospital, we made a recommendation that care plans should be audited to ensure that they were reviewed and updated, and accurately reflected interventions, particularly if each individual's identified needs had changed. The action plan we received from the service advised us that a regular audit cycle was put in place. We heard that there continues to be a regular monthly audit cycle of care plans that then goes to the Cygnet Healthcare regional clinical governance group.

For this visit, we were pleased to find that the care plans were holistic, while still being individualised, covering a core set of needs, with additional care plans identified where required. There were standardised areas that were set out such as personal needs, communication, mental health needs, restrictions on freedom, potential risks and physical health; we found the information in these to be person-centred and up-to-date. There were

positive behaviour support plans, and information relating to the care plans was provided in an accessible easy read format for individuals, where appropriate.

We found that the chronological account of care on a day-by-day basis was integrated into the care plans, that there was detailed information relating to the specific behaviours and actions of the individual, with interventions that the staff provided being clearly documented and associated to the care plans. We were aware that for some individuals, sharing the information on the electronic care plans might not be possible, however, we did find that in these records, the responses and reactions of the individual was added to the content of the care plan.

Following on from our last visit to the hospital, we had recommended that there was better linkage between the recording of risk on a daily basis and what was recorded or reviewed in care plans in relation to risks. The action plan we received indicated that a new online system was being rolled out. We found, as per the action plan, that with the new system, there was a detailed risk assessment record that was updated on a daily basis, at the start of each day; this was formally evaluated every three months. We found the documentation for this to be easily accessible on the electronic system.

Multidisciplinary team (MDT)

There have been some positive additions to the MDT since our last visit. In addition to the two consultant psychiatrists in learning disabilities, the charge nurse, a deputy and a hospital manager, along with a team of staff, including registered nurses, senior support workers, and support workers, there is a speech and language therapist, an occupational therapist and an activity coordinator, and a clinical psychologist supported by three assistant psychologists.

We found that all of the above disciplines provided input to the MDT meeting, and there were comprehensive records detailing the joint multi-professional working that was taking place. While MDTs for each individual took place on a monthly basis, there were also care programme approach (CPA) meetings that were scheduled every six months. The information of the MDT meetings noted who had attended the meeting, the focus of the discussions and agreed outcomes. Care needs were reviewed in the MDT meetings, and again at CPA meetings, where other professional such as the care managers and/or social work officers from each individual's home area were invited to attend. We found the reports that were prepared for CPA meetings incorporated all of the professionals working with the individual patients, and we also saw evidence of family involvement at these meetings. We also saw evidence of individuals being supported to participate and where possible, attend the MDT and CPA meetings, with the record reflecting each individual's views of their care and treatment, and information about the meeting being provided in an accessible read format.

There was a recommendation in our last visit report that highlighted the need for Makaton training to be delivered to staff in the hospital. We noted that in the response from the service, they had advised the Commission that there had been a delay with this as a result of the pandemic. However, on this visit, we were pleased to see that significant progress had been made in this area. We heard that all staff have been trained, and individuals in the unit are encouraged to develop their own signing. We heard about the use of widgets signs and symbols, as well as "the sign of the week" that was practiced at the community meeting, and the Makaton Choir that had been established, led by the SLT and supported by other members

of the MDT. On the day of the visit, Commission staff were able to join in with learning a festive song, using signing to help build the skills of the patients as well as the staff. The hospital has in place an inclusive communication audit that reviews alternative augmented communication, such as the posters and information displayed around the unit, and the talking tiles, which tailored to individual need, using the voices of members of staff.

Use of mental health and incapacity legislation

On the day of the visit, all individuals in the hospital were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The paperwork for the mental health act was in good order, easily located and up-to-date.

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) under the Mental Health Act were in place where required, were kept along with the medication prescription kardex and corresponded to the medication being prescribed. We found that for one T2 certificate that there was a paper copy only, which had not been added to the electronic file; we brought this to the attention of the medical staff on the day.

For those that we met with, and whose notes we reviewed, who were detained under the Mental Health Act, we found that they had been advised of their rights, in an accessible read version and this was discussed with them at their reviews; those who were subject to detention were either supported to, or could access, advocacy services and legal representation.

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 patient had nominated a named person, we found this stored on the electronic record.

There were also a number of individuals whose care we reviewed, who were under the Adults with Incapacity (Scotland) 2000 (the AWIA)). We found this documentation accessible and accurate, and noted that the guardians/proxy decision makers had been consulted where required.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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. Where s47 certificates were in place, we found they had an associated treatment plan.

Rights and restrictions

Access and egress to Cygnet Wallace Hospital is locked, which is proportionate with the level of risk for the individuals in the unit. Some of those that we spoke with could leave the unit for unescorted time off; for others, they required to be escorted.

Of the 10 individuals in the hospital, seven were on intensive levels of observation, with restrictions in place that varied from one-to-one during the day, to some who were on two-to-one throughout the day, and during the night. While we found risk assessments, risk

management plans and positive behaviour support plans in place, we discussed our concerns about the levels of restriction that were in place for some individuals. We noted that for a number of individuals, staff were positioned outside their rooms, working on laptops and not engaging with the individual themselves. We fed this back at the meeting with the team at the end of the day, and suggested that the guidance produced by Health Improvement Scotland on improving observation practice could be helpful.

We heard that psychology were involved in supporting individuals to develop coping skills to try reduce behaviours where staff were required to remain with them constantly, however, for some individuals, progress was slow and not easily sustained. We discussed with the MDT that what could be considered as the use of long term segreg-tion with some of the patients should be reviewed regularly, and the Commission's guidance on seclusion could be useful in monitoring of this. Our guidance can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf

We heard that recently there had been some successful discharges, but the for the majority of patients that were in the hospital at the time of our visit, we were told that they could have had their care needs met had a more bespoke service been developed, or commissioned by the services with their health and social care partnership. At the time of our visit, there were five people on a waiting list for Cygnet Wallace Hospital.

In our last report, we had made a recommendation about specified person restrictions. This is when sections 281 to 286 of the Mental Health Act are required to 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. We were pleased to find that for this visit, there were no individuals who were specified.

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 pleased to find that there was a strong focus on activity in the Hospital, supported by both the occupational therapist and the activity coordinator. From those that we spoke with, we heard that they were encouraged to have a variety of activities, in and out with the hospital. We heard that they had dedicated one-to-one time with the OT, the activity coordinator and the SLT for this, and that they had been able to develop a structured activity programme, with the aim of achieving 25 hours per week in a range of activities. These included cooking, shopping on their own, doing their own laundry, gardening, painting/art classes, out for trips in the car, escorted walks and visits to their family; one person we spoke with told us about her job and that they "couldn't ask for anything else" as they enjoyed all of the things they were doing. We were impressed that the 25-hour week dedicated to activities was audited. The MDT monitored and collected the information about an individual's

engagement in in their structured programme, and this was fed back to the person when their care was reviewed, but also through the Cygnet Hospital governance meetings.

Since our last visit, there has been an expansion in accessible spaces that can offer activities. The lower ground floor in the hospital has now been renovated to provide more therapeutic space, with a large arts and crafts area, books, access to a computer and a range of games that patients can access when with staff. There was also a much-improved focus on diet, with educational information in an easy read format visible in the kitchen/dining areas, and encouragement for those who required foods that had varying texture modification levels.

The small garden area is now more readily accessed, and we could see that some individuals had already established their own areas for planting, decorating and maintain this space; we heard that further work is planned for next year. We also heard about forthcoming plans to develop a cinema room, which will create this type of experience for those that are unable to leave the unit.

The physical environment

The layout of the unit consists of seven individual rooms and three 'flat' style rooms that have en-suites and limited kitchen facilities. We were able to see some of the individual rooms, but not the flats on the day of the visit, due to clinical activity. The individual rooms were personalised to each person's own wishes.

There were a couple of day areas on the upper floor of the hospital, one that was more inviting with soft furnishings, while the other did not appear to have a specific function and the decoration of the room was quite sparse. We discussed this with the hospital manager during our walk-round of the unit. There is a staff office that is centrally located, where staff are visible and a number of meeting and interview rooms that have been developed to support these functions. In the main corridor, there is clear, accessible signage, and talking tiles are situated in key locations such as the entrance to the unit, across from the main meeting room and at the central hub in the unit, where the lift to the lower ground floor is accessed.

In our last report we made a recommendation about refurbishing the current hospital environment. While there has been some progress with the works on the ground floor, the main corridor areas on the upper floor, and the smaller day room needs to be refreshed and repainted. We were advised that Cygnet are looking at other properties in the Dundee area, as an alternative to Wallace Hospital, but so far have not found the ideal location or building. We look forward to hearing how this develops in the future.

Recommendation 1:
Managers should develop a plan to update and improve the appearance of main corridor and day area in the unit.

Summary of recommendations

Recommendation 1:
Managers should develop a plan to update and improve the appearance of main corridor and day area in the unit.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report.

A copy of this report will be sent for information to The Care Inspectorate and 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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