Mental Welfare Commission for Scotland

Report on announced visit to: Levendale and Tayview Wards, Lynebank Hospital, Halbeath Road, Dunfermline KY11 8JH

Date of visit: 12 December 2022

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.

Levendale Ward was due to close this year, with patients expected to move into their own supported accommodation in summer 2022. Unfortunately, delays were encountered and discharges from hospital were not achievable in the timescale planned. On the day of our visit, there were four patients in Levendale Ward. All patients will be discharged into community placements with packages of care provided by Fife local authority. All four patients had a diagnosis of intellectual disability with some patients also diagnosed with mental illness.

At the time of the visit to Levendale Ward we were not given a definitive timescale for the moves, due to continuing building work required to make the tenancy safe for residents.

Tayview Ward was a bespoke facility and accommodated two patients, who typically required high levels of support, in an environment that reduces potential risks associated with behaviours that challenge.

We last visited this service on 16 November 2021 and made no recommendations. Our last visit to Levendale Ward was on 15 November 2019 and we made a recommendation that managers should ensure that an active, joint, multi-agency approach was applied in relation to delays in discharge through existing processes, with clear actions and outcomes put in place for individual patients.

On the day of this visit we wanted to follow up on the previous recommendation and also to hear how patients in both wards have progressed since our last visit. We were particularly interested in hearing whether the delay in the patients moving from Levendale Ward had impacted on their well-being. We were also keen to meet with both patients who reside in Tayview Ward as we were informed both patients have had significant improvements in their mental health and well-being and opportunities to reduce restrictions had been achieved.

Who we met with

We met with, and reviewed the care of six patients, we also met three of the patient's relatives. We spoke with the service manager, nurse in charge on the day of the visit, the lead nurse and members of the senior leadership team at the end of our visit.

Commission visitors

Anne Buchanan, nursing officer

Lesley Paterson, senior manager (practitioners)

What people told us and what we found

Care, treatment, support and participation

On the day of our visit there were four patients that were accommodated in Levendale ward and two patients who have been cared for in Tayview for several years. We spoke with staff who work in Tayview Ward, and they were enthusiastic about the patients they care for. It was clear they had invested time and expertise to ensure both patients received a person-centred approach to care and treatment. The patients we spoke to were glowing about the input they received, not only from the nursing team but from the wider multi-disciplinary team (MDT) including occupational therapy, psychology and having many opportunities to spend time with family. For one patient there was a significant improvement in their mental and physical well-being and they were happy to share their experiences of working with the MDT; "I feel safe and confident now" "the staff, all of them, have helped. I'm now able to spend time outside, it feels great".

Tayview ward was a bespoke unit. From meeting with the patients and having an opportunity to be shown around their own accommodation it was clear both patients had been encouraged to personalise their rooms. The rooms were comfortable, with attention to detail for their sensory needs with staff taking the lead from their patients to ensure they feel safe and relaxed.

Care records and care planning

Care records were reviewed for both patients in Tayview Ward. Each had care plans that were based upon evidence and outcomes from assessments. While there was clear evidence of ongoing and review of risk assessments, there was also a focus upon their emotional and physical well-being. All care plans were personalised with evidence of input from a range of professionals and family members.

Of the family members we spoke to they were keen to acknowledge the care their family member had received with descriptions of care including, "staff are one in a million" "they have a lovely relationship with my family member, and I feel supported too".

Risk assessments and care plans were regularly reviewed, evaluated and updated as required. This was important as there had been a significant improvement in both patient's well-being with assessments and care plans amended and updated accordingly. Patients in Tayview ward required attention to their physical health. We were able to see regular input from primary care professionals for example chiropody, regular national screening programmes and dietician to ensure both patients are provided with opportunities for good nutrition and weight management.

Similarly, in Levendale Ward, we reviewed care records for all four patients. While there had been a significant delay for all patients moving on from hospital-based care, there was evidence of the MDT's commitment to ensure patients were provided with ongoing support, treatment and therapeutic engagement. For all four patients, this was clearly important, however we were told by nursing staff they would like to provide more recreational and therapeutic activities but, this was not achievable due to continuing problems with recruitment and retention of staff. Some of the patients were supported by health and support staff from the local authority. This blended approach to providing support was established to enable a

smooth transition from hospital to community, with staff who would be knowledgeable of all patients. The difficulty with the prolonged delay had meant staff from the local authority had not been keen to extend their contracts in light of not having a definite timescale for patients moving into their community placement. While it was recognised by staff both from the local authority and health that this blended approach to team working had been successful, there were limits to how patients can be supported with activities and therapeutic engagement when resources were considered insufficient.

During our visit to Levendale ward we were able to observe interactions between staff and patients, with patients appearing confident and in good spirits. Staff knew their patients well and while there were times when staff had to intervene due to patient's behaviours, this was undertaken with compassion and skill.

To ensure participation and supported decision making, staff should be able to evidence how they have made efforts to do this and that actions which are part of the care plan are clear and attainable. Having reviewed several care plans, we were pleased to see they were consistently of a high standard. Each patient's care plan 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 their own objectives to enable a sense of well-being.

All patients had detailed risk assessments. For some patients they required a more formal framework to risk assessing and risk management. We discussed this with staff on the day of our visit as we proposed that all patients who required additional risk assessments and risk management plans should have those updated prior to moving from hospital-based care into the community. Staff agreed this would be appropriate, as community staff will be required to work with individuals without the support from trained nurses within the hospital.

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

Contact with relatives

During our conversations with relatives, they highlighted their frustrations about the delay for moving their family member from hospital to their community placements. They were concerned about the lack of communication in relation to timescales and often felt in the dark about the tenancies and the work having to be undertaken to ensure they were ready for their family member. While relatives remain frustrated, they were largely happy and positive about the care their family member received. Relatives felt listened to, however for some there were concerns about risk management plans and the restrictions placed upon their family member. We are aware there are ongoing discussion in relation to this and will seek updates from the service.

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.

Where patients were identified as having limited understanding of their detention status there was evidence of how staff communicated with them to support their understanding.

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 required, and corresponded to the medication being prescribed. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date.

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 (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.

All documentation pertaining to the Mental Health Act and the AWIA, including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date.

Rights and restrictions

Both Tayview Ward and Levendale Ward continued to operate a locked door, commensurate with the level of risk identified with the patient group.

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.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

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

Therapeutic engagement and recreational activities were jointly provided by a range of professionals including staff from the local authority. There was a focus upon occupation, connections and relationships to ensure the transition from hospital-based care to community was sustainable and seamless for each patient. We were pleased to see restrictions placed upon one patient had been reduced significantly with opportunities for them to visit local

community activities which we were told has brought about a new confidence in them. Both staff and patients agreed that undertaking activities jointly, whether this was in the ward environment or in the community was important to them. However, frustrations remained where there were limited numbers of staff to enable therapeutic and recreational activities.

The physical environment

As previously stated, Levendale Ward was due to close with the four remaining patients moving into their community placements. On the day of the visit, we were keen to review the current accommodation as we were told it would not be considered fit for purpose. We agreed the ward was not appropriate environment for the four remaining patients. We were invited to see several patients' bedrooms, communal areas and rooms that had been condemned due to the presence of mould. On the day of our visit the dining room floor was being replaced as there were concerns for patient's safety as the floor was unstable. This was an issue throughout the communal areas of the ward. Mould was clearly a significant problem with several rooms having to be closed off permanently to stop patients being adversely affected. Patients' bathrooms had evidence of mould and discoloration, with flooring torn and requiring to be taped down. This was also the case throughout the ward with flooring, plasterwork, bathrooms and bedrooms appearing in a dire state of disrepair.

We raised our concerns throughout the day of our visit and particularly in relation to the evidence of mould throughout the building. We were told staff had also raised their concerns, air quality measurements had been taken and while within an acceptable range, there remained concerns for patients and also for staff working in this environment.

We have asked for regular updates of how the senior leadership team plan to ensure everyone who remains in this building are supported and identified risks are reduced or removed. As the timescale for patients moving from the ward to their new accommodation in the community has not been confirmed, we will remain in contact with the service and will expect the service to carry out any necessary adaptations to improve the current environment.

Recommendation 1:
Managers should ensure Levendale Ward is safe for patients and staff and regular air quality assessments and measures are carried out.

Recommendation 2:
Where it has been identified the timescale for moving patients from Levendale Ward to their community placement will be further delayed, managers should assess whether patients should remain in this current environment or identify an alternative for the duration of their hospital-based care.

Summary of recommendations

Recommendation 1:
Managers should ensure Levendale Ward is safe for patients and staff and regular air quality assessments and measures are carried out.

Recommendation 2:
Where it has been identified the timescale for moving patients from Levendale Ward to their community placement will be further delayed, managers should assess whether patients should remain in this current environment or identify an alternative for the duration of their hospital-based care.

Any other comments

We were impressed with the commitment from all staff based in Tayview Ward and Levendale Ward. We recognised for staff supporting patients in Tayview Ward, their knowledge, compassion and eagerness to improve their patient's lives is commendable. We were told by patients and their relatives the input they receive was valued and ongoing support meant they were confident for the future.

The care team in Levendale have had to face a number of challenges out with their control, however they have remained stoic in their attempts to engage with their patients' knowing relationships built on trust and empathy are the cornerstone of compassionate care.

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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