Mental Welfare Commission for Scotland

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

Date of visit: 18 April 2024

Where we visited

Mayfield Ward has been designed for adults with learning disability and autism. On the day of this visit, there were ten individuals, all of whom required a high level of support from nursing staff.

Individuals in Mayfield Ward can often present with behaviours that challenge. Each individual benefits from a multidisciplinary team (MDT) model of care with input provided by medical staff, nursing, psychology, occupational therapy (OT), speech and language therapy, and referrals to other allied health professionals, as required. Individuals also benefit from the training staff have had in relation to positive behaviour support (PBS). PBS is a model that encourages the MDT to assess an individual's presentation, for example, considering the environment; relationships; physical and mental well-being; areas where the individual may experience difficulties and in turn display behaviours that challenge. To support a whole team model of care and treatment, each person had an additional team formulation; psychological formulations are beneficial for the individual and staff as they provide an understanding of presentation and behaviours. Nursing staff in the ward have had additional training and are skilled to work with individuals to ensure care and treatment is individualised and person-centred.

Relatives told us they have 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.

Who we met with

We met with three individuals and reviewed their care records; we also had an opportunity to speak with seven relatives.

We spoke with the service manager, the senior charge nurse, the lead nurse and consultant psychiatrist. We also had the opportunity to meet with senior leadership team at the end of the day to provide an overview of our visit and discuss future plans in relation to electronic record keeping.

Commission visitors

Anne Buchanan, nursing officer

Mary Leroy, nursing officer

Denise McLellan, nursing officer

Andrew Jarvie, engagement and participation officer (lived experience)

What people told us and what we found

We had the opportunity to meet in person three individuals who were receiving care and treatment in Mayfield Ward. We were told “staff support me a lot as I’m moving into the community” “staff listen to me, I don’t really want to be in hospital but, I feel safe and listened to”.

Of the relatives we spoke to, they were generally positive about the care, treatment, and support their relative had received in Mayfield Ward. “We work together as a team”,” staff are fantastic, and we cannot fault them” However, we heard from every relative that we spoke to of their ongoing frustrations in relation to the length of time their relative had been in hospital and, the challenge of finding a suitable placement in the community. This frustration was not necessarily levelled at the day-to-day care or commitment from staff in the support individuals receive in Mayfield Ward. Rather, the length of admissions was felt to be unnecessary and compromised individuals’ right to live in their communities alongside neighbours and family.

We heard from staff that they were equally frustrated with the duration of time individuals had remained in the ward. Their goals were to assess individuals, to support people to reach their optimum level of functioning and where possible, learn new skills to support a sustainable discharge. Where this model was at times challenged was typically due to individuals being ready for discharge however, finding a suitable tenancy and appropriate package of care was considerably difficult. We were told by the service of the difficulties encountered in 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, having support staff with the right skills to work with individuals, and an intensive transition period to enable a sustainable discharge.

Unfortunately, for individuals there are limited opportunities for those resources however, the service endeavours to work with their local authority partners to enable transfers of care from hospital to community settings. We are keen to receive updates from the service as we were told there will be some progress with patients moving on in the coming months.

Care, treatment, support and participation

When we spoke with relatives, we considered a number of areas where they could provide input and participate with care planning. From our conversations with relatives, they felt very much included and involved in all areas in terms of care and treatment for their relative.

Relatives were invited into the ward to participate with providing support, and staff sought their views, often asking for advice when seeking an understanding of an individual’s presentation. For one individual who was in the transition phase of moving on from hospital-based care to a community placement, their relative was very much part of the transition and had been working closely with the new support provider; feedback from everyone was very positive. This approach to working with relatives and family members was a model the staff were keen to develop and appreciate that for relatives, being part of an individual’s care and treatment was important to them.

Care records

Care records were held on electronic record system 'Morse', and this system has been in operation since our visit to the ward last year. While the ward-based team had become familiar with the functions included in this electronic system, they had found some issues with uploading specific documents. Therefore, some records for individuals remained in hardcopy.

Nevertheless, we were pleased to see care plans were detailed with evidence of relatives and individuals participating in their creation. Furthermore, members of the MDT were also invited to contribute to care planning therefore, each plan of care was bespoke and person-centred. Unfortunately, there were some areas in the electronic records that we found difficult to locate and for this reason, we thought a review of the system would be beneficial.

Having easy access to risk assessments, multidisciplinary records and daily continuation notes is essential as it would allow staff to keep up-to-date with any changes or progress. Last year we made a recommendation in relation to written daily record keeping and proposed having access to 'canned text' would be helpful. The ward-based team were keen to have this function included into Morse however, this has yet to happen, and the team had been informed adding canned text may be difficult. We suggested the team engage with mental health and learning disability services in Scotland who use Morse and who have been able to add canned text as a function. Those services may be able to advise Fife Health and Social Care Partnership inpatient services in relation to this.

Recommendation 1:
Managers should ensure the electronic record system supports all relevant functions necessary for staff to update individuals care records.

Multidisciplinary team (MDT)

Individuals were supported by a range of professionals including nursing staff, psychiatry, OT, technical instructor, speech, and language therapist. Where required, individuals receive input from other allied health professionals for example, physiotherapists and dietician. The ward has a model where the MDT supports individuals to reach emotional and physical well-being and develop strategies for emotional regulation; these were based upon positive behaviour support principles.

The ward-based team had a detailed programme in place to ensure individuals' physical well-being was regularly monitored. Relatives told us they valued the commitment staff had to promote healthy living strategies, nutrition, and exercise. This model was based upon the primary care approach, with national screening programmes in place and early identification of physical health concerns.

Where additional learning was required, individuals worked closely with OT to gain skills in preparation for living in the community. There was, however, a recognition that each individual needed to achieve their identified goals at their own pace therefore, the MDT met regularly to discuss progress.

Where an individual needed extra input or support, staff who could provide this were invited to work with the individual. We were pleased to see individuals who were preparing for discharge were supported by the community support provider prior to their discharge. The

transition period went at a pace that was comfortable for the individual. Meeting and working with the community support staff had been identified as essential for successful and sustainable discharges.

Use of mental health and incapacity legislation

On the day of our visit, nine individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (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 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 and corresponded to the medication being prescribed. We were informed that there was pharmacy input to the ward to assist with governance around authorising treatment.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (AWI 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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. During our last visit to Mayfield Ward, we found discrepancies and made a recommendation for managers to put in place a governance system to ensure section 47 paperwork was in order. We reviewed all section 47s and found on this occasion all certificates were in place, with accompanying treatment plans.

For those people that were subject to AWI Act legislation, we found paperwork relating to welfare guardianship was in place and easily located. Staff were familiar with the legal framework and understood their responsibilities to ensure welfare guardians were consulted in respect of the powers granted in individuals' orders.

For individuals who had covert medication in place, all appropriate documentation was in order, as all individuals had recording of reviews or the pathway where covert medication was considered appropriate. The Commission has produced good practice guidance on the use of covert medication.

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 this level of 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, 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, which explained the need for the restriction.

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

We met with the advocacy service before our visit to Mayfield Ward. Advocacy staff were very familiar with the ward and had been supporting individuals for a long period of time. They described some tensions with the scope of their engagement and had previously felt that their presence was not always perceived to be welcomed by the ward-based team. Individuals had expressed their concerns to advocacy about the length of their admission and had spoken of their ongoing frustrations with finding suitable community placements.

Advocacy proposed recruitment of staff was an issue and the ward often had to employ bank/agency nurses. Advocacy felt this was a concern as bank and agency staff were not familiar with individuals receiving care in Mayfield Ward and this had led to concerns raised by individuals in the ward. We discussed the issues raised by advocacy services with the senior leadership team and suggested it may be beneficial for staff to meet and discuss the concerns raised to the Mental Welfare Commission.

Activity and occupation

For individuals in Mayfield Ward, there had been a significant effort to engage in fundraising opportunities. We were told by individuals 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.

Relatives also told us they found activities offered to their relative gave them an opportunity to engage with a range of professionals and a sense of belonging in their community, particularly with raising funds for various local charities. Individuals and staff valued the work undertaken by the 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 an individual's sense of well-being and acceptance. Where individuals 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 that individuals were given opportunities to engage in activities that they chose and were able to find a connection with.

The physical environment

Mayfield Ward was a large building with several clinical rooms, a separate space for visitors and 'pods' that allow for individuals to have their own space. Mayfield Ward had 10 individuals, who had their own bedroom, with several having their own suite of rooms. This was important

to them, as sharing social spaces with their peers could be stressful. Individuals 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 individuals in Mayfield Ward, sound could be distressing. There was a therapeutic kitchen in the ward, which allowed individuals to learn and maintain cooking skills and food preparation.

There was outdoor space for people 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 a lack of privacy due to the housing development adjacent to the garden. We raised the lack of privacy as a concern during our last visit to Mayfield Ward. We were pleased to learn funding for fencing had been made available to ensure individuals would have privacy in the garden and we look forward to seeing the improvements when we next visit Mayfield Ward.

Any other comments

During our last visit to Mayfield Ward, we were aware from our conversations with individuals receiving care, their relatives, and the staffing team that there was a determination to provide person-centred care. This was a similar representation during our recent visit to the service.

There were ongoing frustrations with finding suitable placements and accommodation for individuals however, the ward team strived to maintain enthusiasm for all the individuals who are currently in Mayfield Ward. We observed interactions between staff and individuals that were kind, good spirited, and energetic. Relatives were happy with the care their family member was receiving, this was important to them and clearly important to the team too.

Summary of recommendations

Recommendation 1:
Managers should ensure the electronic record system supports all relevant functions necessary for staff to update individuals care records.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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