Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 20 June 2024

Where we visited

Daleview Ward is a 10-bedded regional low secure forensic unit situated in the grounds of Lynebank Hospital. It accommodates people with a diagnosis of learning disability, who have come into contact with the criminal justice system.

Daleview Ward is male only and admits individuals over the age of 18 years, with no upper age limit. As the East of Scotland facility, it offers 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.

We last visited this service in May 2023 on an announced visit and made recommendations in relation to activity provision and recruitment into an activity coordinator position. The response we received from the service was a view that this specific post would be recruited into however, at the time of this recent visit, that had yet to happen.

We were informed by the service following our visits to various inpatient wards and units the intention was to recruit into several activity co-ordinator posts as it had been recognised this position was highly valued by people who use inpatient services throughout the region. Unfortunately, little progress has been made and this was brought to our attention once again by ward-based staff and individuals receiving care and treatment.

Who we met with

We met with nine people. Of the nine that we met with, we reviewed the care records of six.

We spoke with the service manager, the senior charge nurse, charge nurses, nursing staff and student nurse. We also had the opportunity to spend time with advocacy staff and at the end of the visit, we met with the senior leadership team.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Susan Tait, nursing officer

What people told us and what we found

We had the opportunity to meet with several people on the day of the visit. Their views about their care and treatment were largely positive, and they told us "I was supported to go home for an important event, it was amazing, staff came too to support me", "I feel listened to, staff go above and beyond to help you", "my last placement wasn't good, I much prefer Daleview Ward". However, for some people being away from family was difficult and they recognised logistically having family visit could be a challenge, particularly if their family did not reside in Fife or surrounding area.

We also had the opportunity to meet with a student nurse on placement in Daleview Ward. They were enthusiastic about the learning experiences provided by the ward-based team and had found the nursing team supportive and inclusive.

Care, treatment, support and participation

On the day of our visit, the ward was calm with individuals and staff engaging in activities, either in small groups or with one-to-one therapy. Interactions between staff and individuals were observed to be kind, thoughtful and staff were knowledgeable about people in their care. Individuals were 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 everyone in the ward and the determination they had shown to support their chosen charities.

People were keen to show us their individualised discharge pathway illustrations also known as 'road to freedom'. With support from allied health professionals including occupational therapy, speech and language therapy and also psychology, individuals had a diagram of their pathway to discharge on their bedroom wall. In these personal diagrams, there were illustrations to recognise their strengths, what needed to be in place to enable recovery, and who would be needed to support them to achieve this. People 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 individuals to engage with the Good Lives Model, an approach that provided opportunities for everyone 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. When we met with and spoke to nursing staff, who were able to inform us of specific goals for individuals in their care. Where individuals had been in Daleview Ward for a considerable period, there was a view that recovery was not a linear process and at times individuals may be making progress however, where there were challenges, those were identified and adaptations to the pathway were made.

This personalised model of care and treatment lent itself well to engaging with individuals, who by virtue of their early life experiences, or experiences in secure settings, had difficulties with attachment and trust. We heard from advocacy services on our last visit about improvements to enable individuals 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 individuals should have the opportunity for meaningful engagement with the review. However,

for some individuals 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 individuals included in every discussion, decision and provided with 'easy read' documentation to ensure they were fully immersed in their CPA. We were keen to hear the views of individuals and whether the improvements to the CPA process had been helpful. We were told having accessible information available prior to each review meeting that invited individuals to communicate their views, goals and identify how they could be supported continued to be welcomed by everyone, including the ward-based team.

Care records

Individuals' care records were held on electronic record system Morse. This system had been in operation since our visit to the ward last year. The ward-based team were now familiar with the electronic record system, but there continued to be some issues with its capacity with documentation having to be stored electronically in other areas of the platform. We were told staff continued to highlight areas that required improvement in relation to storing significant documents and the need for easy access to ensure communication was not compromised.

On our last visit we identified several person-centred care plans, with evidence of individuals' participation with their creation. On this recent visit, we were disappointed to note this was not the case and we saw several where it was difficult to identify where an individual had participated in determining what they had hoped for in terms of goal setting, interventions to support recovery and who would support them to achieve their aims.

Where we identified person-centred care plans, we were able to see clear evidence of the views from the individual, reviews were detailed, and collaboration was throughout. 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.

Recommendation 1:

Managers should ensure an audit of current care plans is undertaken in order to identify care plans that would not be considered person-centred and make necessary changes to confirm individuals are supported to participate with their care and treatment.

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 reviewed daily progress notes in individual care records, and we were able to identify where there had been efforts made to gather a subjective view from an individual however, this was not always consistent. We would like to have seen evidence of a subjective and objective view from individuals and nursing staff to help understand whether recreational/ therapeutic engagement had been a positive experience. Or, where an individual had experienced any challenges that day, what were the strategies that had enabled them to feel secure again. A consistent, richer narrative through each individual's progress notes would

enable the reader to appreciate the day-to-day contact staff have with individuals and how an individual viewed their care and treatment.

Recommendation 2:
Managers should consider undertaking an audit of daily record keeping, ensuring there is a consistent approach to promote both the subjective and objective views of individuals and nursing staff.

Multidisciplinary team (MDT)

Daleview Ward had a broad range of staff providing input to care and treatment, including nursing staff, a consultant psychiatrist, occupational therapy (OT), psychology, art therapy and until recently, speech and language therapy. For individuals who required additional support from other allied health professionals, referrals were made to specific services, such as physiotherapy, dietician or speech and language therapy. Each member of the MDT delivered care and treatment specific to their expertise and provided weekly feedback to the clinical team, outlining individuals' 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 people who had experienced trauma. Individuals had regular input from psychology, and there was an emphasis on psychological formulations.

Psychological formulations were helpful for both individuals and staff, as they provided an understanding of each individual's presentation and behaviours. There were excellent detailed assessments available from allied health professionals; this supported individuals to consider their strengths and areas that required additional skills and support. Each individual met with their consultant psychiatrist regularly; again, we could see there was a keenness to consider individuals' progress. The approach during reviews was to highlight positive behaviours and where an individual had experienced challenges, those were explored with compassion and support to make adaptations.

We spoke with individuals who had been receiving care in Daleview Ward for a considerable duration of time and while this had led to frustrations, they were able to inform us of their plans for discharge. We asked whether there had been regular contact with their own local authority social workers if they did not reside in the region of Fife. We were told by individuals that it was often CPA reviews that prompted social workers/ mental health officers to make arrangements to visit individuals in Daleview Ward. We requested a view from staff, and they concurred that social workers would not regularly keep in touch with individuals, and it was often only as part of CPA reviews. We suggested to the senior leadership team that while we can accept logistically it may not be straightforward to visit individuals in Daleview Ward, it is a statutory necessity that contact is maintained, particularly in terms of supporting individuals to move from hospital-based care into community placements.

Use of mental health and incapacity legislation

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

The individuals we met with during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act or CPSA. Individuals were provided with accessible information to support their understanding of legislation.

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 all in place and corresponded to the prescribed psychotropic medication.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this in their file.

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 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. On the day of the visit, we were unable to locate several certificates and their accompanying treatment plans. We brought this to the attention of the ward-based leadership team as it is necessary to complete all parts of a section 47 certificate and identify treatments/ interventions that are legally authorised for staff to undertake.

Recommendation 3:
Managers as a matter of urgency should undertake an audit of all section 47 certificates and ensure medical staff provide an accompanying treatment plan where necessary

Rights and restrictions

Daleview Ward continued to operate a locked door, commensurate with the level of risk identified for individuals in that care setting. Most individuals had unescorted time away from the ward and this was reviewed regularly by the MDT. Individuals we spoke with would have preferred additional time away from the ward and told us that they struggled with the restrictions placed upon them, as is required in a low secure setting.

We noted that all individuals had access to independent advocacy. Currently this provision was offered in-person, with individuals provided with opportunities to meet with advocacy at a time that was convenient for them. Individuals could ask for support from the service for a range of issues, or for support during mental health tribunal hearings. Equally, to ensure individuals had access to legal representation, nursing staff supported them to maintain contact with their legal representative. Mental health officers also provided support and guidance in relation to hearings, whether related to the Mental Health Act or criminal procedures matters.

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 an individual 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 all authorising paperwork was in place.

When we are reviewing individual's files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We could see evidence of when individuals had been supported to document their views in relation to the care and treatment they wished to receive. With input from advocacy and nursing staff it was evident that individuals had shared their views, and an advance statement was recorded and filed in their electronic records.

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.

Activity and occupation

We were told Daleview Ward had not recruited into an activity coordinator post following our last visit; we had made a recommendation to support the view from individuals that they would value this position in the ward.

When we met with individuals receiving care and treatment in Daleview Ward they were enthusiastic about the charitable causes they supported, and efforts made to support them. People also told us they really enjoyed the ward staff's commitment to offer themed activities throughout the year, which were often in relation to sport, and this was always welcomed.

Nevertheless, we were also told that the nursing staff were busy and had competing demands and at times, being in the ward could be "boring" as there may not be scheduled activities. We were disappointed to find during our visit that while the ward-based team and allied health professionals did offer recreational and therapeutic activities, there was not a structured, planned programme available. We would therefore propose that the service may wish to look at funding activities from the existing budget individuals have.

Recommendation 4:
Managers should ensure a daily programme of structured activities is available for individuals.

The physical environment

Daleview Ward is a bright, well-maintained, and welcoming environment. Individuals had their own bedroom with en-suite facilities, and were encouraged to personalise their rooms and adapt their space to ensure it provided a sense of well-being. Some individuals had their discharge pathway illustrations on their walls and pictorial strategies to help reduce anxiety, stress, and distress. Individuals were keen to show us their bedrooms and told us they were given opportunities to invest in their personal space, which they had found beneficial and rewarding.

The communal areas of the ward were bright and inviting. The dining room benefitted from bespoke furniture and individuals were keen to tell us it was very comfortable. The ward benefitted from accessible outdoor space however, one of the gardens was not in use as it

required significant amount of remedial work and had very little privacy from the new housing development. We asked whether there was a possibility of adapting the garden to include appropriate screening. We were told this was under review and considerations for funding were being discussed, along with finding a company to carry out the remedial work. This may be extremely costly and with the benefit of an accessible large garden already available for people to use that had space for sports, socialising, seating, and is private; there may need to be a decision whether investment in the other garden is necessary. We asked to be updated as we are aware individuals and staff benefitted from access to outdoor space and having opportunities to use all available space would be welcome.

Any other comments

We wish to acknowledge the commitment the ward-based team and allied health professionals continued to have with supporting individuals currently receiving care and treatment in Daleview Ward. We were told that ongoing recruitment into nursing posts had been a challenge for many months and for nursing staff this had been a source of frustration. Nevertheless, we could see a determined workforce who made huge efforts to provide person-centred and compassionate support to everyone placed in Daleview Ward. We were told there would be several newly qualified nursing practitioners starting in the service soon and we look forward to meeting them on our next visit to Daleview Ward.

Summary of recommendations

Recommendation 1:
Managers should ensure an audit of current care plans is undertaken in order to identify care plans that would not be considered person-centred and make necessary changes to confirm individuals are supported to participate with their care and treatment.

Recommendation 2:
Managers should consider undertaking an audit of daily record keeping, ensuring there is a consistent approach to promote both the subjective and objective views of individuals and nursing staff.

Recommendation 3:
Managers as a matter of urgency should undertake an audit of all section 47 certificates and ensure medical staff provide an accompanying treatment plan where necessary

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Managers should ensure a daily programme of structured activities is available for individuals.

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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