Mental Welfare Commission for Scotland

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

Date of visit: 24 September 2019

Where we visited

Mayfield Ward is an assessment and admission ward which is situated in the grounds of Lynebank Hospital, Dunfermline, Fife. It accommodates patients with a diagnosis of learning disability. Mayfield is a mixed-sex ward and admits patients over the age of 18 years with no upper age limit. It has 13 beds, 10 of which are open .Some of the bedrooms can be converted to day areas and function as sleeping and living areas. These are used for patients with distressed behaviours that require management, support and treatment away from the general ward. This means that on the day of our visit there were 10 patients admitted with three of these using more than one bed space.

We last visited this service on 6 February 2018 and made a recommendation in relation to auditing the completion of section 47 certificates and their accompanying treatment plans.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendation and also look at care and treatment, physical health care, patient rights in relation to any restrictions and the underlying reasons for delays in discharge. These are similar themes to our previous visit but we are aware that they remain pertinent.

Who we met with

We met with and/or reviewed the care and treatment of six patients, five relatives and/or welfare guardians on the day of our visit.

We also spoke with the clinical service Manager, the lead nurse, senior charge nurse, charge nurse and the consultant psychiatrist who provides input to the ward. We also met a range of nursing staff throughout the day.

Commission visitors

Paula John, Social Work Officer

Juliet Brock, Medical Officer

What people told us and what we found

Care, treatment, support and participation

The patients that we spoke to on the day told us that they had good relationships with nursing staff and other members of the clinical team. We were also able to observe these interactions. They added that they saw their doctor regularly and, where possible, managed to spend time off the ward. Some patients however, did add that they felt they had been in hospital for a long time and were keen to move on from Mayfield Ward.

In addition, most family members and friends that we spoke to were likewise positive and felt that the care and treatment being offered to their loved ones was of a good standard. They felt that communication was good and that they were regularly invited to ward meetings and discussions. Some family members said this was not their experience but felt that by raising the issue it had improved. Again, the admission had been too long for some families and they were frustrated at what they saw as a lack of progress in relation to planning for discharge.

We raised this issue with senior staff during the day and we were advised that six patients were experiencing a delay in relation to discharge. Staff advised that the reasons for this were complex and involved issues with locating appropriate housing, identifying suitable care and support packages and issues in recruiting relevant staff to be able to carry out such plans. We were told that good liaison existed between social work and health services and that community social work staff were currently involved in updating the proposed plans for the patients concerned.

We were also advised that a strategic oversight group of the Fife Health and Social Care Partnership (HSCP) has been in place to progress any difficulties and identify potential gaps in service but we understand that this has lost momentum recently. We are concerned at the length of time that some patients have had to stay on Mayfield Ward especially in light of our past work on this issue which can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-06/no_through_road.pdf

We therefore make the following recommendation and will also be writing separately to Fife HSCP to seek assurance on actions being taken to address continued delays.

Recommendation 1:

Managers should ensure that an active, joint, multi-agency approach is applied in relation to delays in discharge through existing processes with clear actions and outcomes being in place for individual patients.

We were advised that Mayfield Ward has a strong multidisciplinary team (MDT) including nursing, psychiatry, psychology, speech and language therapy, pharmacy and art therapy. There is also availability to refer individual patients to podiatry, physiotherapy, dentistry and a dietician. This holistic approach was evidenced in the care plans and there was good input noted in relation to physical health care. All patients had a passport to health in place and physical health care reviews were taking place.

MDT meetings take place weekly and decisions and outcomes are clearly recorded. There was less evidence of patient participation, but we were advised that advocacy services regularly attend the ward. In addition, family members are also invited to attend MDT meetings and this was confirmed by all of the family members that we spoke to .The Care Programme Approach (CPA) is used for all patients on the ward, this being a more formalised case management system with individual plans and a case co-ordinator being in place. Minutes were on record and were detailed with the case co-ordinators being attached.

We also looked at care plans and found these accessible and well organised. They were personalised and related well to the goals and objectives of each patient's care. Risk assessments and positive behaviour support plans were also on record and were being regularly reviewed. We thought that some of the standardised paperwork developed for the service was particularly helpful in contributing to background information on patients and the specific details of delivering care and treatment, for example the personal details form and the named nurse weekly recording sheet.

In some cases however, we did find that the completion of these documents was inconsistent both in terms of quality information being stored and the number of standard forms on each record. We discussed this with senior nursing staff who felt that they would continue to address these gaps through an audit process.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Use of mental health and incapacity legislation

We were able to locate the relevant paperwork for those patients that were subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') and this was completed appropriately.

Where relevant, copies of welfare proxy's guardianship orders and powers of attorney under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') were also found within records.

In addition, we found some issues with certificates to authorise treatment (T3s) under the Mental Health Act. These authorise medical treatment where an individual is not able to consent. We addressed these with staff on the day and they were able to deal with these promptly. We were advised that there is pharmacy input to the ward to assist with these issues.

We also found two issues with s47 paperwork of the AWI Act which again we were able to discuss with staff. However, given that we found issues with this on last year's visit to the ward, we are repeating our last recommendation.

Recommendation 2:
Managers should ensure that a system is in place to ensure consistent completion of s47 paperwork with accompanying treatment plans where required.

Rights and restrictions

Mayfield Ward has a locked door both at the main entrance and internally where double doors separate the clinical areas from staff and interview rooms. There is a locked door policy in place and the security is clearly in place for the welfare and protection of patients. Not all patients are subject to compulsory measures, but access to and from the ward is individually care planned for. We were also advised by nursing staff that they like to encourage all patients, where possible, to spend time off the ward. This is usually with a nursing escort.

As mentioned previously, some patients were being nursed by flexible use of the accommodation where rooms are used as individual bedroom living and activity areas. The decision to manage patients in this way was determined at an MDT meeting and is reviewed and time limited. A policy on the use and application of restrictive practices and seclusion was in place and this was clear and detailed. More information on seclusion can be found on the Commission's website at:
https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf

We were advised that advocacy services are regular visitors to the ward and that patients are informed of their rights. We did note some gaps in rights based care in relation to explanation of detention status, information on named persons and advance statements, but this did not apply to all patients.

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

Regular activities are taking place with patients and these are undertaken by both nursing and occupational therapy (OT) staff. Activities involve both group and individual sessions and we were able to observe some low level one-to-one activities taking place on the day. There is an OT dedicated to the ward who assists in both individual planning and undertaking functional assessments in the ward kitchen. Each patient had an activity time table contained within their case records and these provided good detail.

Despite this we did get some feedback from patients that they were bored and would like more options in relation to activities. We were also advised by staff that they did not have access to hospital transport for the ward and this limited the amount of activities that could take place at times. Managers might want to take note of this issue and discuss with staff and patients how this can be taken forward.

The physical environment

Mayfield Ward is now nine years old and still impresses as a modern building. It has undergone some changes and refurbishment since opening, and these appear to have made an overall difference to the patient and nursing experience.

Mayfield is a large building and has a clinical area and a separate staff area incorporating meeting rooms and, interview rooms. These are comfortable, with a range of literature available for families and carers. The ward itself is a series of corridors running off from a large circular communal area. There are also dining spaces and a therapeutic kitchen. All bedrooms are single rooms and have en suite facilities.

There is access to a garden from the living area and this is spacious and secure.

Since our last visit to the ward there has a been a new housing development adjacent to the hospital site and this has resulted in privacy being compromised for some patients, as these houses back onto the ward communal spaces and the garden/ We would suggest that attention is paid to issue.

Recommendation 3:

Managers should improve the privacy of patients in the ward area and ensure that this is maintained specifically in the garden area where they are being directly overlooked.

Summary of recommendations

1. Managers should ensure that an active, joint, multi-agency approach is applied in relation to delays in discharge through existing processes with clear actions and outcomes being in place for individual patients.
2. Managers should ensure that a system is in place to ensure consistent completion of s47 paperwork with accompanying treatment plans where required.
3. Managers should improve the privacy of patients in the ward area and ensure that this is maintained specifically in the garden area where they are being directly overlooked.

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.

ALISON THOMSON
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 MWC 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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