mental welfare commission for scotland

Mental Welfare Commission for Scotland

Report on unannounced visit to:

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

Date of visit: 16 January 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Cygnet Wallace Hospital (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. Wallace Hospital is a mixed-sex environment, registered for ten adults. The hospital covers no specific geographical area and accepts individuals on an assessment basis.

On the day of our visit, there were nine people residing in the hospital. Due to a significant refurbishment taking place, a decision had been taken not to use the vacant bed.

This visit to the hospital was unannounced. We last visited this service in November 2023 on an announced visit. We made one recommendation that managers should develop a plan to update and improve the appearance of the main corridor and day area in the hospital.

During this visit, we wanted to follow up on the previous recommendation, to meet with people receiving care and treatment and to hear about developments in the service. We saw a significant programme of development being undertaken by the hospital, which has gone through an extensive renovation programme and was in the process of being extended from a ten-bedded to an 18-bedded hospital, using both floors of the existing building.

There had been significant transformation and financial investment. When we visited, the lower floor of the hospital building work was almost complete, and eight residents had recently moved downstairs. There was still one person in the upper floor of the hospital, which was a considered decision made by the multidisciplinary team (MDT) to minimise any negative impact to them.

Who we met with

We met with two people and reviewed their care records. We also reviewed the care records of another two people. As this was an unannounced visit; it was not possible to speak with any relatives on the day of the visit. However, we spoke with one relative after our visit had taken place.

We also spoke with the hospital manager, clinical manager, nurses, support workers, consultant psychiatrist, and speech and language therapist.

Commission visitors

Sandra Rae, social work officer

Gordon McNellis, nursing officer

Tracy Ferguson, social work officer

Jenn McIntosh, student nurse

What people told us and what we found

We met and spoke with individuals who had been in the hospital and had received care and treatment for many years.

We heard mostly positive comments regarding 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 some staff were “good.” People said that they “felt safe in the hospital” and that moving to the hospital had been better for them than the service they were in, before the transfer to Wallace Hospital. We heard that for one person that being there had really helped them to “become calm and understand that my medication helps me as well.” For another, it had helped them to “be able to talk to my family about my feelings.” We heard from people that they liked their consultants, that they were told what was happening and were actively involved in the plan to help them get well and move back to the community. Some individuals told us they were “disappointed” that there were no houses in the community for them to move to and they “felt stuck” in hospital.

We were told people planned their individual activities with staff. We were also informed that there was a weekly meeting with other people receiving care and treatment in the hospital and they jointly decided what activities they would do. We spoke with a relative, who was also a welfare guardian, who told us that they felt the staff worked well to support their family member and the communication was excellent. The relative told us they felt fully informed in all aspects of the care and treatment of their family member.

We also heard some comments from the individuals who had moved to the new refurbished environment downstairs the week before our visit. We were informed that this had been “excellent”, and the new location was quieter. We were also told at times the hospital could be noisy due to how some people communicate, which some people found “annoying”. People informed us that the time off the ward was well planned and organised between them and staff. We were told this had increased confidence for one person who felt that they “will be able to manage better” when they leave the hospital as they had been waiting for a long time for suitable accommodation.

When we spoke with the extended team, we heard that there had been significant improvements in staffing in the service. These included a stable senior management team, improved staffing levels, and allied health professional (AHP) input. We were told this had significantly improved staff morale and improved care. There were no staffing vacancies at the time of our visit, which we were told also added to the significant improvement with the continuity of care. We found there were registered mental health and learning disabilities nurses working in the hospital, and a senior support worker rostered for each shift.

We saw from rotas that a nurse was always on day and night shift, alongside a senior support worker and 11 support workers per shift. This level of input was required to manage the one-to-one and two-to-one supports required for some people in the hospital. We were also informed this level of staffing was essential, as each person had 25 hours social support weekly built into their care provision.

Care, treatment, support, and participation

Care records

The hospital had an electronic system as well as specific documents in different paper folders for everyone. The team were reviewing the system, as it was clear from speaking to staff that finding and knowing where documents were held, could be confusing.

We reviewed care plans that were detailed and personal-centred, with evidence of monthly reviews taking place. The care plans covered a core set of needs, with additional care plans identified and completed where required. There were standardised areas set out with in each care plan such as personal needs, communication, mental health needs, restrictions on freedom, potential risks, and physical health; we found the information in these care plans to be relevant and up to date. We found positive behaviour support (PBS) plans that focussed on the individuals' strengths and information relating to the care plans was provided in an accessible, easy read format for individuals, where appropriate.

We found detailed risk assessment records that were updated at the start of each day, and formally evaluated every three months, as were the PBS plans. The hospital also reviewed risk assessments, along with risk management plans every three months using short term assessment of risk and treatability (START). When reviewing these documents, we found these to be detailed and clearly identified current risk, current needs, the person's strengths, and had clear indicators for risk management.

We found that the chronological account of care recorded on a day-by-day basis that was integrated into the care plans and gave detailed information relating to the specific behaviours and actions of the individual, with the interventions that the staff provided being clearly documented and linked 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 were added to the content of the care plan.

We noted a welfare guardian would have preferred to have had more input to the care plan of their relative. The hospital was addressing this and liaising with the guardian who has recently been appointed.

We discussed the dynamic support register (the register) which was put in place by Scottish Government in May 2023 to prevent people with learning disabilities living in hospitals for longer than necessary, or in out-of-area placements which they/their family had not chosen for them to live in. It was designed to help professionals working with people with learning disabilities to respond better to situations where there is a need for a more intensive level of care management and support the development of local community placements.

The register is a tool to support local planning and decision-making and is used and maintained by each local area. The register is also kept nationally so that there is consistency in how the data is recorded across all areas and shows the numbers and services, or lack of services in each area. We were pleased to hear that the area that the person came from prior to being admitted to Wallace Hospital took responsibility for recording the person in their area numbers. This was important to ensure accuracy in capturing the national picture, as opposed to recording all the individuals who lived in the hospital as being from the Dundee area, when Dundee had no responsibility for them.

Wallace Hospital is a private hospital and the funding for each person's care comes from the area who purchased the placement, hence why it was important that these cases were accurately recorded.

Multidisciplinary team (MDT)

The hospital had a robust MDT in place. This consisted of two consultant psychiatrists with learning disabilities expertise, a hospital manager, a clinical manager, a charge nurse, registered nurses, senior support workers, and support workers. There was also a speech and language therapist (SLT), an occupational therapist (OT), an activity co-ordinator and a clinical psychologist supported by three assistant psychologists.

We found that all the above disciplines provided input to the MDT meeting, and there were comprehensive records detailing the joint multi-professional working that was taking place. MDT meetings for each person took place monthly and the MDT meeting recording tool noted who had attended the meeting, the focus of the discussions and agreed outcomes. Care needs were reviewed during the MDT meetings.

In addition to the MDT meetings, there were care programme approach (CPA) meetings that took place every six months. CPA is a framework used to plan and co-ordinate mental health and learning disability care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre. Care managers and/or social work officers and any other relevant professionals from the individual's home area were invited to attend CPA meetings. We found the reports that were prepared for CPA meetings incorporated all the professionals collaborating with the individual, and we saw evidence of family involvement at these meetings.

We noted evidence of individuals' being supported to participate and where possible, attend the MDT and CPA meetings, with the record reflecting their views of their care and treatment. Information from the meeting was provided in an accessible read format.

Delayed discharges were discussed at MDT and CPA meetings. We heard this could be a challenge and people were delayed for prolonged periods of time and were in hospital for years longer than needed due to difficulties in securing future suitable placements or accommodation for them. Hospital managers informed us that they felt unable to influence this.

Of those individuals who were in the hospital at the time of our visit, we were told that seven could have had their care needs met elsewhere or have a more bespoke service had it been developed or commissioned by the services in their local health and social care partnership area. The hospital informed us that the communication with individuals' partnership areas was positive and there was a proactive relationship with the person's health board area and consultant psychiatrist.

As Wallace Hospital is an independent hospital, the Mental Health (Conflict of Interest) (Scotland) Regulations 2017 apply. The hospital proactively recognised that there could be a perceived conflict of interest in relation to the second medical examination required for compulsory treatment orders. The hospital therefore ensures that all medical second opinions come from the person's home health board.

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 documentation that related to the individuals' legal status was in order, although files were not as organised as they could be. We discussed this with medical staff on the day of the visit.

Recommendation 1:
Managers should ensure that regular audit of all legislative paperwork is introduced to ensure information contained in files is present, current and easily located.

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.

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 individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We were informed that two individuals had nominated a named person.

Where individuals were subject to the Adults with Incapacity (Scotland) Act, 2000 (AWI Act), we found this documentation accessible and accurate in the care records we reviewed. We noted that the guardians/proxy decision makers had been consulted where required in most cases. A new welfare guardian informed us that they were keen to be more involved in the care planning of their relative, which staff were responsive to.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the 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. We found all relevant s47 certificates were in place and had an associated treatment plan.

Rights and restrictions

The entrance to and exit from Wallace Hospital was through a locked door. This was required due to the level of risk for the individuals in the hospital and to maximise their safety. Some of those that we spoke with, could leave the hospital for unescorted time out; others were always required to be escorted. There was no locked door policy displayed on the door inside the hospital to inform of this. When we brought this to the attention of managers, we were informed that this was being addressed.

The plan was to introduce a ‘talking tile’ to inform people of the locked door information. Talking tiles are an effective communication aid to support those with enhanced communication needs. We heard there was usually locked door information displayed at the hospital door; however, due to the ongoing refurbishment work this was not in place.

We were advised that access to advocacy is through Dundee independent advocacy service (DIAS), which is accessible and the use of this service has been encouraged by the hospital team.

Of the nine individuals in the hospital, seven were subject to enhanced levels of clinical observation, with restrictions in place that varied from one-to-one interventions during the day, to some who were on two-to-one interventions throughout the day, and during the night. While we found risk assessments, risk management plans and PBS plans in place, we noted that for a few individuals, staff were positioned outside their rooms. For some people, this was indicated as part of their risk assessment. For others, it was important to them that they always had staff with them and we heard from some individuals that they "felt safe" with the level of observation, care and support they needed.

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 made a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied. There was one person specified with restricted use of their phone, with appropriate paperwork in place. For another person we found an innovative, voluntary, detailed plan had been agreed and worked well for them however, although it had not been signed.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 did not find any copies of advance statements in the files we reviewed.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We were pleased to find that there was a strong focus on activity in the hospital, supported by both the OT and two activity co-ordinators who worked over seven days. From those that we spoke with, we heard that they were encouraged to participate in a variety of activities, in and outside the hospital.

We heard that everyone had dedicated one-to-one time with the OT, the activity coordinator and the SLT and that they had developed a structured activity programme, with the aim of achieving 25 hours per week participating in a range of

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[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

activities. These included cooking, shopping on their own, doing their own laundry, gardening, painting/art classes, trips in the car, escorted walks and visits to their family. One person we spoke with told us about her employment in the hospital and that they “couldn’t ask for anything else” as they enjoyed everything they were doing.

We heard that at the time of our visit there were only two staff members who were able to drive the hospital transport. This was proving to be challenging but was being actively being addressed by hospital managers. Public transport or taxis were being used in the short term, but there was recognition that this was not always possible, nor a viable long-term solution. We found this could impact on the persons activity taking place and their need for ongoing continuity in their activity, due to their complex needs.

The MDT monitored and collected information about an individual’s engagement in in their structured programme, which was fed back to the person when their care was reviewed, and also through the hospital governance meetings. We were pleased to see that the 25-hour week dedicated to activities was audited.

We heard that two of the individuals in the hospital had secured paid employment and how proud and included they felt being part of the workforce.

The physical environment

The entrance to the hospital was bright and newly decorated. The layout of the hospital consisted of two floors. The lower floor refurbishment was almost finished when we visited; however, the upper floor was still having major works, and we could not see this in full.

The lower floor appeared quite clinical, as the individuals had only moved downstairs a week before our visit. We were able to see some of the individual rooms, on the day of the visit. The individual rooms were personalised to each person’s own wishes. We heard that due to the length of time people stayed in hospital, some had gathered many belongings, meaning their rooms could become cluttered. This was an ongoing area that the hospital continued to address, and we heard they had been buying containers to store individuals’ belongings and supporting them to pack and store them.

We were advised that once fully renovated, the hospital will have 18 bedrooms, with the staff office centrally located, meaning staff would be visible. Since our last visit, there had been an expansion in accessible spaces that offered more activity options.

The lower ground floor in the hospital had 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 people could access when with staff. We saw that a modern sensory room was almost complete. We noted that there was 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 was readily accessible, and we saw that some individuals had already established their own areas for planting, decorating and maintain this space; we heard that further work was planned for the garden area. We also heard about forthcoming plans to develop a cinema room, which will create a similar experience to an external cinema for those that are unable to leave the hospital.

On the ground floor, main corridor, we found little in the way of accessible signage, except Makaton. We were informed this was due to the refurbishment and the focus on settling the individuals first. We heard that talking tiles would be reinstated in key locations, such as the entrance to the hospital, across from the main meeting room and at the central hub in the hospital, where the lift to the lower ground floor was accessed.

Whilst we appreciate the situation of the time of our visit, we strongly feel that signage is essential to support the communication needs of individuals and critical to the needs of those in the hospital who require continuity, orientation, and effective communication.

Recommendation 2:
Managers must ensure that appropriate signage is in place for individuals with enhanced communication needs, as alternative communication methods are essential to improve and support understanding and orientation.

Summary of recommendations

Recommendation 1:
Managers should ensure that regular audit of all legislative paperwork is introduced to ensure information contained in files is present, current and easily located.

Recommendation 2:
Managers must ensure that appropriate signage is in place for individuals with enhanced communication needs, as alternative communication methods are essential to improve and support understanding and orientation.

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 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 an individual's care, treatment, and support are 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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