Mental Welfare Commission for Scotland

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

Date of visit: 11 August 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

Mayfield Ward is an admission ward that provides assessment and treatment for adults with a learning disability, who have a psychiatric illness and/or autism and present with behaviours that are complex to manage.

The ward provides care for up to 13 individuals and on the day of our visit, there were nine individuals, all of whom were being nursed under continuous intervention and required a high level of support from the nursing staff. Five of those individuals were nursed in a secluded pod area in the ward.

The senior charge nurse (SCN) told us that due to the complexity of individual needs on the ward, there would tend to be a higher staffing ratio, with 10 staff working most shifts, which included registered and unregistered staff.

We last visited this service in April 2024 on an announced visit and made a recommendation about the health boards electronic recording system, MORSE.

On the day of this visit, we wanted to follow up on the previous recommendation and to hear about the progress that had been made around discharge planning. The Commission had been alerted to a young person being admitted to this adult ward and therefore we wanted to review this young person's care and treatment.

Who we met with

We met with five people and reviewed the care notes of those five individuals. We met with or spoke to seven sets of relatives.

On the day of the visit, we spoke with the SCN and ward-based staff**.** At the end of the visit, we met with members of the NHS Fife senior leadership team.

Commission visitors

Tracey Ferguson, social work officer

Gordon McNelis, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

For the individuals in Mayfield Ward, we were unable to have detailed conversations due to the complexity of their illness. We introduced ourselves and were able to have brief interactions with most; with some individuals we were able to gather more information. We observed individuals engaging and responding to staff throughout the day. Some were on continuous interventions and we saw staff supporting and responding to their needs in a calm and considerate manner.

Individuals we met with were positive about the staff on the ward. They described staff as “supportive, caring and good at listening”. Two individuals we met with told us about the support they had from advocacy in helping them with their rights. Both individuals were able to tell us about their discharge plans and told us that they felt involved in the process. One individual told us that they saw the doctor regularly while another person told us that they did not feel listened to by the doctor. Some individuals told us that having their own rooms was important to them as the ward could be noisy. A few people spoke to us about the activities they enjoyed on and off the ward. One individual told us that they saw their social worker regularly and had a positive relationship with them.

Feedback from relatives was positive about nursing staff, with most relatives telling us that they felt involved and that communication was good. Relatives told us that they attended regular meetings where their family member’s care and treatment was discussed, providing them with an opportunity to raise any questions. We spoke to a few relatives who told us that they had seen the care plans and been involved in developing these. A number of the relatives we spoke with commended staff on their knowledge and skills in managing complex presentations and how they had seen their family member progress. Most of the relatives told us that the information shared with them was informative and that there was a range of printed information in the visitor’s room, which was of benefit to them, especially at the time of admission to the ward.

One relative raised some concerns about the environment that their family member was in and how restraint and seclusion was regularly applied, often having an impact on their ability to visit the ward. We agreed to follow this matter up with the SCN.

Most concerns raised with us from relatives was around discharge planning and the lack of progress. Relatives told us of their frustrations in raising this issue for years and how there had been little to no progress. Relatives told us that they attended regular meetings, however, when the subject of discharge planning was raised the recorded outcome was “no update, no progress”.

We were told that seven out of nine individuals were ready for discharge and that three individuals had a planned discharge and were progressing towards this.

However, for the other four, there had been no progress since our last visit, which was concerning.

The Commission published a report in January 2025 about the circumstances of people with a learning disability and complex needs who have been in hospital for 10 years or more. This report can be accessed here.

We were aware that several people in this ward had been delayed for a lengthy period and wanted to find out about individual's progress with regards to discharge planning.

Of the seven individuals, three people had been in this hospital for over six years, with the longest person being, 11 years. Two people had been in the hospital between one and three years and the other three had recently been admitted. Two people had been delayed between five and seven years, three people between one and two years and two people for less than 12 months.

Care, treatment, support, and participation

In reviewing the care records, the level of detail in the documentation provided a clear understanding of the staff's investment in getting to know the individual and what was required to meet individual outcomes, from the admission stage and throughout their stay in hospital. In speaking to the staff, we gained the sense that the staff team knew the individuals well and had extensive knowledge and experience of people in their care.

On the day of our visit, we saw individuals and staff engaging in activities, some in small groups or in one-to-one therapy.

We found detailed nursing assessments and saw where these had been updated. Detailed risk assessments and risk management plans were in place, and we saw that those documents had been regularly reviewed and updated.

We found evidence of detailed, holistic, strength-based care plans, with identified interventions to support the person to meet their goals and there were regular reviews taking place that included individual participation, where possible. We found care plans that had been devised as 'easy read' or were in a pictorial format to support individual involvement and understanding.

We found that daily recordings by nursing staff were mostly detailed and provided an overview of the individuals' presentation on that day, which incorporated their views as much as possible. We discussed one individual record with the SCN where we found some language that was not in a positive behavioural support framework. The SCN agreed to address this. We would have liked to have seen a more consistent approach in the daily recordings and were pleased to hear that the service was

introducing 'canned text' to support staff to ensure the key areas in an individual's presentation were accounted for.

We were told that the SCN provided a monthly care assurance report to managers and that the charge nurses were involved in the audit processes. This enabled the senior leadership team to identify any specific issues and address any performance management concerns, along with good practice issues in the ward team.

Care records
Individuals' care records were held on electronic record system MORSE. We heard from staff last year that there had continued to be some issues with the system's capacity with storing documentation electronically in areas of the platform. Staff were keen to highlight areas that required improvement in relation to storing significant documents and the need for easy access to ensure communication was not compromised.

We were provided with an update and told that there had been improvements made and that where staff had highlighting areas, these continued to be addressed. We look forward to hearing more about the improvements of this system on future visits.

In May 2022, the Scottish Government committed £2 million every year to NHS Boards to implement annual health checks for people with learning disabilities across Scotland. Annual health checks have been evidenced to be clinically effective in detecting unmet clinical conditions, and in improving the management of long-term conditions. NHS Boards are required to report to Scottish Government on an annual basis with data on implementation and delivery of health checks.

We were told that the ward-based staff continued to carry out the annual health checks of all the individuals. We found detailed recordings in relation to physical healthcare monitoring and intervention. The importance of physical healthcare was evident through the assessments, care planning and daily observations. We discussed one individual's care further and were told that there had been a lengthy consultation process and involvement between the local general hospital and Mayfield Ward to develop a protocol should this individual require medical treatment. We have asked for a copy of this protocol.

Multidisciplinary team (MDT)
This ward continued to have comprehensive input from a range of multidisciplinary professionals into people's care and treatment, working effectively in addressing their complex needs in a holistic way.

The MDT meetings took place every week where the various professionals including nursing staff, the consultant psychiatrist, the occupational therapist (OT), the psychologist, and pharmacist all met to discuss care and treatment, or more frequently, depending on the stage of the individual's journey. Each member of the

MDT provided weekly feedback to the clinical team, outlining an individual's progress which we noted in the recorded minute of the meeting.

Relatives told us that they had the ability to join the MDT meeting or would receive feedback from nursing staff and had the opportunity to discuss any issues with the consultant psychiatrist.

For individuals who required additional support from other allied health professionals, we were told that referrals were made to specific services, such as physiotherapy, dietician or speech and language therapy.

The MDT meeting records that we reviewed provided an update regarding progress from each professional involved, along with individuals' views. While these records were lengthy, we found that they were collated daily continuation notes from between each meeting, with no actually summary. There appeared to be a duplication of records and we discussed this further with the SCN. The SCN told us that there was a test of change occurring at present, to better enhance the MDT recording of the meetings, which we found from the audits that were being carried out. We look forward to hearing more about this on our next visit.

For the individuals who had been identified as ready for discharge or their discharge was delayed, some of the meeting records lacked detail as to what progress was being made around this. We were told that the mental health officer (MHO) and the social worker would attend these meetings, but at times were unable to provide information about progress towards discharge.

Of the seven individuals in the ward who had been identified as ready for discharge, we discussed each individual's progress and plans for discharge. While it was positive to hear of progress for some, we were concerned to hear about the lack of progress for others. We will continue to follow up on these individuals and request an update in three months' time from the clinical service manager.

We heard that there had been good links developed with the senior managers in the Health and Social Care Partnership (HSCP) and that there was a recognition that a joined-up approach was required to ensure an effective and successful discharge for the individual.

Recommendation 1:
Senior managers must ensure that a clearly defined protocol and/or pathway is developed in partnership with the HSCP to support a fully collaborative approach to discharge planning for all individuals in Mayfield Ward.

Recommendation 2:
Senior managers should ensure that actions that are being taken to progress, and updates on all delayed discharges are clearly recorded at the MDT meeting and that

this information is shared with the individual, and their relative, carer or welfare proxy, as appropriate.

Use of mental health and incapacity legislation

On the day of our visit, all individuals were subject to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was available in the electronic files.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to people who are detained, who are either capable or incapable of consenting to specific treatments. All individuals had a T3 certificate in place which authorised their treatment under the Mental Health Act.

Three individuals had a covert medication pathway in place, and these were all in order, with evidence of reviews taking place. The Commission has produced good practice guidance on the use of covert medication.[1]

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 (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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. Section 47 AWI Act certificates were in place along with accompanying treatment plans that had been completed in accordance with the AWI Act code of practice for medical practitioners. All of the above certificates were easy to locate and stored with each individual's prescription Kardex.

For individuals who were subject to a welfare guardianship order, we found copies of the order in the file.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. An individual must have capacity to nominate a person, and we were told that those who were currently on the ward would not have the ability to nominate someone.

Rights and restrictions

Mayfield Ward was locked 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 that was balanced with the level of risk and vulnerability being managed.

[1] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

The ward staff, the MHOs and advocates continued to support people with their rights, and we found information that had been provided to individuals in accessible and pictorial format.

There were five individuals being nursed in a 'pod' area and seclusion was documented as part of their care and treatment. We were told that the seclusion policy was being reviewed and given the recent admission of a young person we advised senior managers that their new policy should include this, as presently, it did not.

Sections 281 to 286 of the Mental Health Act provides 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, including reasoned opinions. The Commission has produced good practice guidance on specified persons[2].

When we are reviewing individuals' files, we looked 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. Given the current clinical presentation of those in the ward, no one had made an advance statement.

The Commission has developed *Rights in Mind.*[3] 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

Some of the individuals that we spoke with were able to tell us about their activities on and off the ward, and how these activities were important to them. Everyone we met with had a weekly planner in place and we found these displayed in their rooms.

We saw that there had been planned events throughout the year and were told that some of these were planned with another ward, based on the same site. We heard that there continued to be a significant effort to engage in fundraising opportunities and we were able to see this commitment and work through pictures displayed on the wall in the corridor.

Some individuals were able to tell us about the role they had in helping with this and that their views and opinions mattered. We also heard from a few relatives that they

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

were pleased that the staff team had managed to support their family member to participate in activities on a one-one and in a group-based setting.

The ward had a dedicated OT who provided functional assessments and was involved in the individuals' discharge planning, supporting their re-integration back to the community. The OT would also be involved in the environmental risk assessment once accommodation had been sourced for the individuals and made recommendations to the HSCP about the suitability of the placement or adaptations that may be required.

Where an individual was preparing for discharge and had an identified commissioned provider from the HSCP, we were told that the social care staff would begin to support the individual with activities in the community and that this support would be built into their transition plans for discharge.

The ward did not have a dedicated activity coordinator, however we were told that nursing staff continued to take a lead in this and for the individuals who were on continuous interventions, activities with staff were factored into their individual schedules.

Senior managers told us that the plan was still to recruit an activity coordinator and that current budgets along with vacancies were being reviewed in order to progress this. We heard that the provision of activities was an area of focus not only across this ward but other services. We gained the sense that staff and the MDT were committed and valued the importance of therapeutic activities, and we saw recordings of these. We will continue to request an update from senior managers about an activity co-ordinator.

The physical environment

Mayfield Ward is a purpose-built facility that opened in 2010. The ward offered a large reception area, with several communal areas, clinical rooms and separate space for visitors. There were nine individuals in the ward at the time of the visit, and each person had their own 'pod' area, which included a bedroom, bathroom, sitting/lounge area.

Due to the complex needs that each individual complex had, having their own space was important, as sharing social spaces with their peers could be stressful and lead to an escalation in behaviours that could challenge.

The SCN told us that the 'pods' were put in place to manage individuals care and treatment in the best way possible in the current environment. Some of the pod areas had access to a garden area; however, the SCN told us that sharing outdoor space could be a challenge and had to be planned.

Individuals had access to two dining rooms and sitting rooms where socialising could take place. There was a therapeutic kitchen in the ward, which allowed individuals to learn and maintain cooking skills and food preparation.
The dining room benefitted from bespoke furniture, and the ward had utilised some rooms that offered a quieter space for individuals.

The corridor wall displayed pictures from activities and themed events that people had participated in over the past year and on this wall, there was a display of the fundraising efforts that had been achieved by individuals and staff, and which charities had been chosen.

Individuals had personalised their rooms and had their activity planner displayed in their pod area. There was also information about people's rights on display.

On our previous visits we were concerned about the lack of privacy in one of the garden areas, due to a housing development adjacent to the garden area. Access to outdoor space is important, and we were pleased to see that a new fence had been put in place that now ensured privacy.

We were able to see that the staff team were doing their best to support individuals in this ward environment, however due to their complex needs, it was evident that aspects affecting sensory sensitivities, such as noise, were often a barrier. We heard from staff that plans to access to outdoor space for some individuals was a challenge and that some rooms in the ward could not be used due the complex presentation and sensory sensitivities for some on the ward.

The purpose of Mayfield Ward is for assessment and we continue to be concerned about the length of time that individuals are in an environment that was not designed for their needs, and where restrictive measures are often required to be put in place.

Summary of recommendations

Recommendation 1:
Senior managers must ensure that a clearly defined protocol and/or pathway is developed in partnership with the HSCP to support a fully collaborative approach to discharge planning for all individuals in Mayfield Ward.

Recommendation 2:
Senior managers should ensure that actions that are being taken to progress, and updates on all delayed discharges are clearly recorded at the MDT meeting and that this information is shared with the individual, and their relative, carer or welfare proxy, as appropriate.

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 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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