Mental Welfare Commission for Scotland

Report on announced visit to:

Stratheden Hospital, Elmview Ward, Springfield, Cupar, Fife KY15 5RR

Date of visit: 19 July 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Elmview Ward is an 18 bedded mixed-sex unit with all bedrooms having en-suite facilities. On the day of our visit there were 13 patients receiving care in the ward. The unit provides continuing care and treatment for older adults who have diagnosis of dementia. The patient population presents with varying degrees of cognitive impairment; for some patients, they require a more intensive level of support from nursing staff, which can include assistance with personal care, mobility and dietary needs. For other patients, with a lesser degree of cognitive impairment, staff will support and encourage those patients to maintain their independence as far as possible.

We last visited this service on 11 November 2015 and made recommendations regarding activity provision and relocation of older adult wards on the Stratheden Hospital estate; we received a response from the service updating us of the actions that they were planning to take

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how patients and staff have managed throughout the Covid-19 pandemic and what, if any limitations this posed for carers visiting their relatives. Furthermore, we were keen to hear from staff how they had adapted their usual ways of working to meet the needs of their patients and the impact of any restrictions imposed during the height of the pandemic. We heard that the restriction on visiting that were necessary to ensure patients were not adversely affected by Covid-19 were managed by the ward based team supporting patients to maintain contact with relatives by using technology. iPads and tablets were purchased and a dedicated space was made available in the ward in order to provide privacy for patients to connect with relatives with the support from nursing staff.

Who we met with

We met with and reviewed the care of seven patients and also reviewed an additional patient's file and spoke with one set of relatives.

We spoke with the service manager, senior charge nurse, lead nurse, consultant psychiatrist, dietician and ward based nursing staff.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

Patients who are admitted to Elmview Ward would typically have had an admission to the assessment ward based on the Stratheden Hospital site. Following a period of assessment which is undertaken by a multi-disciplinary team (MDT), patients are transferred to Elmview Ward for continuing care and treatment, as their needs have been assessed as requiring a higher level support from nursing staff. While the majority of patients are older adults, there are a number of patients who have developed dementia at a younger age. The ward-based team recognise this can be extremely difficult for families and make every effort to ensure patients and their families are supported. The team provides information and advice in relation to understanding dementia-related illnesses in the younger age group.

We were keen to hear how staff support patient's physical health as well as their mental health needs. Nursing staff have been encouraged to attend additional training to enhance their skills in physical health screening and to work with their medical colleagues to recognise those patients who may be at risk of falls.

During our visit we saw interactions between staff and their patients which were warm, good-natured and relaxed. We saw staff taking their time with their communication with patients. There was a sense of calmness; staff we spoke to felt it was important their patients felt safe and secure in light of how symptoms of dementia can sometimes cause patients to feel disoriented and distressed.

The clinical team have developed a model that includes risk assessment tools and interventions to consider patients who may be at risk of falls or physical health deterioration due to the nature of their illness. The MDT meet weekly to review patients' presentations. Included in these reviews are; prescribed medication, physical health including blood pressure, screening for infections, dietary/fluid intake and any issues related to movement and mobility. Adaptations to care and treatment plans are undertaken in a timely manner to ensure any issues are highlighted and managed, to improve outcomes for patients. While still in the early stages, this model has found evidence of improvements, with a significant reduction in falls and related physical complications. The ward-based team are supported by a quality improvement practitioner and weekly updates are provided to ensure progress is maintained.

Along with focusing upon patients' physical health care needs, the nursing staff work with a model of care that specifically supports patients who present with stressed and distressed behaviours. The Newcastle Model supports a more psychological approach to understanding patient's behaviour. Nursing staff have been encouraged to attend additional training in relation to the Newcastle Model to promote a team approach to care and treatment. To further assist staff and patients there is an aim to recruit two psychologists to embed this model in the older adult wards on the Stratheden Hospital site.

We reviewed patient's care plans and found there was evidence of a person-centred approach with information gathered from patients themselves, their relatives and members of the multi-disciplinary team. There was evidence of regular reviews, it was noted who would be supporting the individual, what interventions were required and what the desired outcomes

would be. Individualised care plans were further extended to include dietary needs and nutrition for each patient. A new initiative had started; "simple pleasures" offers patients' foods and fluids they are particularly fond of. This may be related to taste or texture. The nursing staff have been working alongside the dietician to enable patients to choose specific food types and vary their diet. This has greatly improved patient's ability to choose the food that is pleasurable to them and staff have found this has been beneficial to their patient's physical and mental well-being. We look forward to hearing how this initiative has progressed during our next visit.

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

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) of nursing staff, psychiatrists, dietician, and activities coordinator and has access to physiotherapy and psychology by referral. Currently, there is limited occupational therapy provision available to patients placed in Elmview Ward. We were told recruitment into occupational therapy posts has been difficult and is considered a long standing issue. We appreciate this frustration as it is recognised occupational therapy offers many benefits for older adults who present with cognitive impairment. From functional assessments to therapeutic activities, occupational therapists play an important role within the multidisciplinary team. We have asked to be updated with recruitment progress for occupational therapists.

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the MDT meetings and provide an update on their views. This also includes the patient and their families should they wish to attend. From these notes, we could see that when the patient is moving towards a transfer of care, for example to a care home, that links are established and maintained throughout the process.

We discussed whether there were any patients currently in Elmview Ward that would be considered delayed in the timescale for discharge. We were told there were four patients currently considered as 'delayed discharges'. The delays are in relation to locating suitable accommodation including in a care/nursing home or packages of care to facilitate discharge back in to the community. This causes a sense of frustration for carers and the ward-based team. A senior nurse has been appointed into a discharge coordinator post to specifically liaise with local authority teams, care homes and colleagues from Fife Health and Social Care Partnership. This new liaison role has assisted with communication between community and in-patient services. There are now regular meetings to ensure patients who are considered delayed discharges from hospital are discussed and updates communicated to all services and patients' families.

Care records

Care records are currently in paper form and include nursing and allied health professionals records, with medical notes kept separately. This is due to change from the end of July 2022 where all patient records will be kept electronically with no separation between disciplines.

We found that care records were straightforward to navigate, and assessments, outcomes and interventions were available to review. MDT minutes from meetings were recorded separately in medical and nursing notes. With the benefit of electronic record keeping, we hope there will be a streamlining of MDT minutes instead of these being recorded separately.

We saw a number of care plans where there was evidence of a partnership approach between nursing staff, the individual patient and their relatives. Some care plans had extended this approach helping the reader to appreciate a subjective patient's view and this had enabled nursing staff to take a genuine individualised approach to care and treatment. This view was shared by relatives we had the opportunity to speak with.

There were a number of assessment tools currently undertaken by nursing staff with the Holistic Older Assessment Tool (HOAT) providing information to assist keyworkers to ensure care plans are person-centred. Furthermore, with keyworkers actively encouraging the completion of "getting to know me" documents, this further strengthened and promoted individualised care and treatment for each patient.

We found 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms in the patient files we viewed, with anticipatory care plans also in place. We saw confirmation of the involvement of relatives in decision-making in relation to these documents.

Use of mental health and incapacity legislation

On the day of our visit, four patients of the 13 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, (Mental Health Act). The patients we met with during our visit had a limited understanding of their detained status. This was in part due to their cognitive functioning related to their diagnosis of dementia. Of those patients who were subject to Mental Health Act legislation, they were supported by staff and independent advocacy services to ensure safeguards were in place.

All documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act 2000 (AWI), including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date.

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 in place where required, and corresponded to the medication being prescribed. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date.

If there was a guardianship under the Adults with Incapacity (Scotland) 2000 Act (AWI), staff were clear on what this meant for the patient.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. Where this was required, we found this in the patient's file.

Rights and restrictions

Elmview Ward continues to operate a locked door, commensurate with the level of risk identified in the patient group.

When we are reviewing patient files we looked for copies of advanced statements. The term 'advanced statement' refers to written statements made under ss274 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. As we have previously discussed the majority of patients in this unit would be unable to write their own advanced statement. Nevertheless, to ensure patients are supported to participate in decisions, nurses should be able to evidence how they have made efforts to enable patients to do this and that the rights of each patient are safeguarded.

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

On the day of our visit we were able to observe nursing staff engaging in activities with patients both in the communal areas of the ward and in the garden. We also received feedback from the nursing team on how they value the work undertaken by the activity coordinator and the difference they have made to the ward. While this is a resource highly valued, it is not available throughout the whole week as the coordinator role is shared with two other wards on the hospital site. This means patients do not have a daily programme of activities either in group work or one-to-one. We were told there are a number of initiatives considered for patients as part of an activities schedule, however with current restrictions in relation to Covid-19, those initiatives will be delayed. We have heard the activities coordinator will be joined by a member of the occupational therapy service and this should help with providing additional activities.

During our interviews with patients they told us how they enjoy engaging in activities either one-to-one or in small groups. While they appreciate the input from nursing staff when the activities co-ordinator is not available, they would appreciate access to more activities. In some patients' care records we saw 'therapeutic and meaningful activity' records. With the addition of new staff, we hope to see this document provide evidence of a wide range of therapeutic and recreational activities for every patient.

We look forward to seeing additional resources put in place for patients and the ideas for the ward for when Covid-19 restrictions have ended as these developments sound both inspiring and therapeutic.

The physical environment

On entering the ward it is clear there has been a great amount of effort to ensure the ward is bright, well maintained and comfortable for their patient population. Bedrooms have been personalised, sitting areas have been designed to ensure the uninterrupted views of the countryside are captured. To help patients who may be feeling distressed or anxious, there is

a quiet sensory room that allows nursing staff and patients to sit with each other in private. Patients can be ‘pampered’ and given time to relax.

For individuals who prefer being outdoors there is a large secure garden with an array of seating for socialising with staff, visitors or just enjoying the quietness of the garden. With raised beds and plans for re-vamping the outdoor space, we are looking forward to seeing the updates staff have envisaged over the next few months. There has been a new sitting room design that has captured a mid-century theme with fixtures, fittings and furniture chosen specifically to help patients feel comfortable in a living room that they may have had from their early adult years.

Service response to recommendations

The Commission made no recommendations, therefore no response is required.

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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