Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 28 June 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.

Muirview Ward is situated in the grounds of Stratheden Hospital. The unit was opened approximately 11 years ago and offers accommodation that is modern and spacious. The ward provides care and treatment for individuals over the age of 65 years, can accommodate up to 24 patients with the benefit of single bedrooms, all of which are en-suite. The ward is separated into two units, both of which have 12 beds. Patients who present with functional illness for example depression, bi-polar affective disorder and psychosis are cared for in one unit and in the next door unit there are patients who have diagnosis of organic conditions for example, Alzheimer's disease and dementia-related illnesses. Care and treatment is delivered by a multidisciplinary team (MDT), including consultant psychiatrists, mental health nurses, health care support workers and student nurses on placement from local universities.

We last visited this service on 21 August 2018 and made recommendations regarding the staff induction process and communication policy for carers, with the aim for capturing relevant feedback and improving the service where appropriate and reviewing the input of activities on Muirview Ward, involving all relevant disciplines.

The response we received from the service in relation to our first recommendation was that an information booklet had been developed for patients and their relatives. The booklet offers information and guidance about Muirview Ward including key professionals working in the unit, their role, daily routine and what to expect from an admission to this unit.

Our second recommendation related to the provision of activities and we were informed that there an activities co-ordinator is now available for Muirview Ward, and will soon be supported by an occupational therapy assistant in the coming weeks.

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 current Covid-19 pandemic. There have been a number of restrictions required to ensure patients were not adversely affected by Covid-19. As visitors to the ward have had to be limited, the ward based team supported patients to maintain contact with relatives by using technology. iPads and tablets were purchased, 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 ten patients and reviewed seven sets of notes. On the day of the visit we did not have the opportunity to meet with any relatives.

We spoke with the service manager, the senior charge nurse, the lead nurse and both consultant psychiatrists. In addition we met with dietician, pharmacist and the activities co-ordinator.

Commission visitors

Anne Buchanan, nursing officer
Tracey Ferguson, social work officer
Graham Morgan, participation and engagement officer

What people told us and what we found

Care, treatment, support and participation

While care and treatment is provided day-to-day by nursing and medical staff, there are a number of AHPs who provide input and are members of the clinical team. We heard of a number of recent initiatives to improve physical health and well-being of patients.

The dietician has been focusing on improving the nutritional intake for patients and was impressed with the nursing team's commitment to focus upon the importance of ensuring that patients not only have food which is nutritious, but enjoy mealtimes.

Additionally, there has been a greater focus upon risk assessments, specifically patients who are at risk from falls. A project was underway over the last few months to review physical health, prescribed medications, dietary intake and the environment to determine whether those areas compromised patient safety. Each patient who was assessed as at risk from falls was reviewed each week by the MDT with interventions put in place mitigate those risks. Initial findings have been favourable with a reduction in falls and the associated harm from falls. Furthermore, nursing staff told us this initiative has helped reduce enhanced observation practice and enabled the team to look at less restrictive engagement.

A nurse consultant specialising in dementia care has been supporting the nursing team to deliver care and treatment appropriate to the needs of this patient population. Furthermore, we were told nursing staff will have the opportunity to undertake training in relation to the Newcastle Model, which is a person-centred approach to supporting patients who present with stress and distress. This model focuses upon a largely psychological approach, which not only benefits patients, but also their relatives and staff. The model identifies the possible cause for distress and supportive interventions to reduce behaviours associated with stress and distress. We reviewed a number of care plans and noted there were interventions that included nursing staff using distraction techniques to help patients who were distressed, however there was very little detail of what those techniques were or how they should be employed. We hope with training in the Newcastle Model and future input from the nurse consultant, care plans will have greater detail and be more person-centred.

Of the care plans we reviewed we would like to have seen evidence of regular reviews; this would have given the MDT an opportunity to see where there has been progress. If, however, there has been little evidence of progress, it is important to consider changing interventions to ensure care is delivered to meet the needs of individuals and their unique circumstances.

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

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Multidisciplinary team (MDT)

The MDT meets weekly to discuss each patient with feedback from a range of professionals. There were detailed minutes from each review, with actions and those who were responsible for carrying these out clearly recorded. There is a recognition that patients who are admitted to Muirview Ward require robust assessments, as there are often co-morbidities present that include mental ill-health and physical health conditions. We saw evidence of assessments that included the Holistic Older Adult Assessment Tool that takes into account, nutrition, fluid, skin integrity, pain and comfort. Following assessment, referrals can be made to psychology and AHPs, such as physiotherapy, speech and language therapy and podiatry, as required.

There is additional input provided by psychology staff and allied health professionals (AHPs), including occupational therapists, physiotherapists, dietician and pharmacists. While AHPs are available by referral, there is currently no dedicated occupational therapy service attached to Muirview ward. Prior to our visit this was brought to our attention by ward-based staff and was recognised as a cause for concern. The lack of OT input was a source of frustration for staff, as additional resources to provide a full weekly activity programme would be welcomed. The benefit that patients with functional and organic illnesses would gain from engagement with occupational therapists is well understood, as is the pivotal role they serve in relation to functional assessments and care planning. We were informed recruiting to nursing, occupational therapy and consultant psychiatrist posts has been an ongoing issue with the latter currently being covered by locum medical staff.

Care records

Care records are currently in paper form with nursing, AHP and 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.

Care records were straightforward and easy to navigate, and included assessments, outcomes and interventions which 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 not be a need for separate discipline's minutes. We are aware that following a period of assessment, patients admitted to Muirview Ward will likely be transferred to one of the other wards based on the Stratheden Hospital site for further care and treatment. We were therefore pleased to see, documentation that was detailed, person-centred care plans for physical health interventions and evidence of communication with patient's carers and relatives. There were a small number of patients who told us they would have liked to have greater participation with drafting their care plans and who had hoped for more connections with community-based support groups.

Use of mental health and incapacity legislation

On the day of our visit, six of the 23 patients were subject to Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) legislation. There was evidence nursing staff had made efforts to support patients with understanding their rights in relation to the Mental Health Act however, for some patients who presented with a significant impairment of their cognitive functioning, their understanding of their rights and restrictions made it difficult to communicate or understand. There is an Advocacy service available to support patients, with nursing staff able to initiate referrals on behalf of patients. Advocacy

attends the ward and support patients in relation to Mental Health Tribunal for Scotland (MHTS) hearings, and support can be extended to carers and relatives too.

To ensure nursing staff can carry out care and interventions that are authorised under the legislative framework of the Mental Health Act and Adults with Incapacity (Scotland) Act (2000) (AWI Act) we were told there will be ongoing commitment for staff to attend training relating to the Acts. This is to ensure patients with significant cognitive impairments are supported in terms of their rights and choices in their care and treatment.

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. Where certificates authorising treatment (T3s) under the Mental Health Act were in place, we found that not all had been completed by the responsible medical officer (RMO), meaning treatment had been given out with the Act. We were concerned to hear that governance processes that had been put in place to ensure treatment is authorised while available, had not been actioned by a RMO. This situation had been not been rectified for a number of weeks, therefore the patient was treated with no legal authority.

Furthermore, we found patients had been given treatment with requests of second opinion doctors overdue; again we would consider any treatment that has been given has been done out with the legal framework of the Mental Health Act. Due to the significance of this, we spoke with the ward's RMOs on the day of our visit. We communicated our concerns and requested patients who were receiving treatment currently considered out with the Act should be informed, as should their relatives, or where appropriate, their named person. Furthermore, the clinical team including medical staff, nursing and pharmacy should review their governance procedures to ensure safeguarding for all patients subject to Mental Health Act and the AWI Act.

Recommendation 2:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular auditing compliance with this should be put in place.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Due to patients presenting with significant cognitive impairment, named persons were not nominated on the majority of Mental Health Act forms.

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. We noted associated care planning in relation to section 47 certificated were in place in consultation with legal proxies.

For patients who had covert medication in place, we were able to locate the appropriate documentation, with evidence of regular reviews to determine whether covert medication was

required. The Commission has produced good practice guidance on the use of covert medication at: https://www.mwcscot.org.uk/node/492

Rights and restrictions

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

On the day of our visit we were aware of continuous intervention taking place. This requires remaining with a patient continuously and requires nursing staff to promote active therapeutic engagement. Due to the level of restrictions we would expect the requirement for this to be reviewed regularly. Unfortunately, we were unable to locate evidence of regular reviews recorded in patients' notes.

Recommendation 3:
Managers should ensure patients who are subject to continuous intervention are regularly reviewed with outcomes clearly recorded in patients' files.

When we are reviewing patient files we looked for copies of advanced statements. The term 'advance statement' refers to written statements made under s274 and s276 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 noted, 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 had the opportunity to meet with the activity coordinator for Muirview ward. 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 valued, it is not available for the full 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 through one-to-one sessions. We were told there are a number of initiatives being considered for patients, as part of an activities schedule, however with current restrictions in relation to Covid-19, those initiatives will be delayed. We also heard that the activities coordinator will shortly be joined by a member of the occupational therapy service; 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 were aware nursing staff often appeared busy and recreational activities were not routinely available. As activities are enjoyed by patients in the

ward, having a documented account of engagement in patients' care records would be helpful in light of the therapeutic outcomes they provide.

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

The physical environment

Muirview ward is bright, well maintained and provides space for all patients to either spend quiet time away from fellow patients or opportunities to socialise. With the benefit of single bedrooms it offers opportunities to personalise bed spaces and patients are encouraged to have photos of friends and family.

We were keen to see the outdoor space particularly the garden area as we were told during our last visit the garden was not used as often as patients would like due to the ground/flooring considered a trip hazard/falls risk. We were therefore disappointed to note the work expected to be carried out to reduce the risk for patients had not happened. We were told by senior nursing staff the flooring required had not been purchased over the years since our last visit however plans were in place for new flooring to be laid. The garden which can be accessed from various points in the ward is not routinely in use. During the warmer weather this would have been considered invaluable and could have offered opportunities for additional therapeutic activities.

Recommendation 4:
Managers should ensure there is a schedule of works for the garden area, and that all work required to be carried out is undertaken timeously to enable patients to utilise the outdoor space safely.

Any other comments

While the ward currently admits patients with diagnosis of functional and organic illness there is likely to be a move towards the ward looking after patients with a functional diagnosis only. Nursing staff report they have seen a significant change in presentations to this service since the start of the Covid-19 pandemic, in March 2020. Those patients who have been admitted have been very unwell, with a significant level of anxiety and self-harming behaviours not usually seen in this patient population, along with depressed mood levels and psychosis. The clinical team attribute this to the impact of several lockdowns over the past two years, and the stress this has caused individuals and their carers. Furthermore, during the first 18 months, there was a reduction in statutory and informal support services. The clinical team suggest this may have led to a sense of isolation for some individuals, and in turn compromised their mental health. The senior leadership team are keen for staff to undertake additional training to ensure patients who present with functional illness are cared for by staff who are able to identify and meet their specific needs.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Recommendation 2:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular auditing compliance with this should be put in place.

Recommendation 3:
Managers should ensure patients who are subject to continuous intervention are regularly reviewed with outcomes clearly recorded in patients' files.

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Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving this report.

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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