Mental Welfare Commission for Scotland

Report on announced visit to:

Cairnie House, Stratheden Hospital, Springfield, Cupar, Fife, KY15 5RR

Date of visit: 3 October 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.

Cairnie House is a 10-bedded ward for men with dementia and is based in the grounds of Stratheden Hospital. We last visited this ward on 13 October, 2020, soon after its opening, having re-located from one of the other in-patient wards based on the hospital site. There was a recognition at that time that patients with significant cognitive impairment required specialist nursing care in an environment with fewer patients and a higher nursing staff ratio. Over the past two years bed numbers have remained the same, however we were told recruiting new staff has been an ongoing issue, with a number of vacancies across older adult in-patient services carrying a significant number of vacant posts.

When we last visited this service, we made a recommendation regarding the need to ensure that care plans included a summative evaluation that indicated the effectiveness of the interventions being carried out, and that detailed any required changes.

On the day of the visit we wanted to follow up on the previous recommendation and also hear the views of nursing staff about the move to Cairnie House, and how this has enabled specialist nursing care for men with dementia and related conditions. We were also keen to hear the views of other staff, relatives and patients on how the past two years have been since the move to the new location and whether the Covid-19 pandemic has continued to cause any long lasting challenges.

Who we met with

We met with, and reviewed the care of six patients, we also met with two relatives.

We spoke with the service manager, the senior charge nurse, and the lead nurse and consultant psychiatrist.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit there were nine patients in the ward; it was calm and quiet, with nursing staff care and support for their patients either individually, or socialising with them in small groups. On the day of our visit we observed interactions between staff and patients which were compassionate, considerate and caring. There was a recognition that this patient population requires a high level of support with all aspects of their care and treatment, including with personal care, dietary and fluid intake, social support and assistance with mobility. Patients appeared comfortable in the company of staff and were typically in good spirits. We were told patients in Cairnie House can display behaviours that challenge, and these can range from stressed and distressed behaviours to communication difficulties.

We heard that the nursing staff make efforts to engage with relatives and view them as being the "experts" in terms of understanding the unique needs for each patient. Of the relatives we spoke to, they were keen to highlight how nursing staff have supported them, telling us that they "feel confident my relative is being looked after and the nurses are always available to speak with me. I can see that their physical health has improved". We also heard how relatives have re-started their informal peer support catch-ups, where there is recognition and understanding of how caring for a relative with dementia can at times be difficult. The relatives we spoke to valued the company of others with similar experiences. We were aware that not all relatives are happy with the care and treatment of their family member, and there are ongoing discussions between the service and relatives; we remain in contact with the senior leadership team and the relatives and have regular updates.

We reviewed individuals' care plans to look at how the nursing team have met the needs of each patient and in particular with the support given during times of stress and distress. We were told a number of the nursing team have had 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, not only benefitting patients, but also their relatives and staff; it identifies the possible cause for distress and supportive interventions to reduce behaviours associated with stress and distress. Nursing staff have been encouraged to attend additional training in relation to this 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 in the older adult wards on the Stratheden Hospital site.

We were pleased to see that in the care plans there was a clear focus on including the views of relatives, and where possible, the views of the patient. Additionally there was input from psychology and allied health professionals in the interventions provided, although we would like to have seen more detail in the terms of how interventions were decided, how those interventions were reviewed and whether goals set out were achieved. Furthermore, having key staff identified to provide specific interventions would be helpful to understand the roles of those staff who are involved in supporting each individual patient.

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.

We heard that the staff team have specifically focused in developing and delivering a model of care that meets each patient's individual needs. This has often been difficult due to the competing demands of keeping patients safe during the Covid-19 pandemic, working with relatives to ensure they were kept updated regularly, while working at times with depleted staff resources.

Multidisciplinary team (MDT)

The MDT meet weekly to discuss each patient, with feedback from a range of professionals. There were detailed minutes from each review, actions noted and those responsible for the actions were clearly recorded. There was a recognition that patients who are admitted to Cairnie House require robust assessments as there are often co-morbid conditions present, including mental ill-health and physical health conditions.

We saw evidence of assessments that included the 'Holistic Older Adult Assessment Tool' that takes into account a range of needs including nutrition, fluid intake, skin integrity, pain and comfort. We were told the physical well-being of each patient was a priority as some patients in Cairnie House have communication difficulties and cannot always inform staff if they are in discomfort. The focus on this has ensured patients receive immediate care in relation to their physical health and has reduced the need for patients to be transferred to medical wards, therefore reducing any stress this may cause to patients. Referrals to psychology and allied health professionals, such as physiotherapy, speech and language therapy and podiatry can be made as required following assessment. We were told there were a number of vacancies at present for nursing staff, as well as the ward based occupational therapist. Currently the ward can make a referral for occupational therapy (OT) input. The ward team recognise having a full time OT would be beneficial, not only to undertake a variety of assessments but also to support nursing staff to work with patients who may require input in relation to activity and occupation.

On the day of our visit there were no patients who were considered as delayed in their discharge from hospital. We were told of a recent appointment of 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 had assisted with communication between community and in-patient services. There are now regular meetings to ensure any patients whose discharge from hospital would be considered as delayed are discussed, with updates communicated with all services and patient's family. Furthermore, when patients do move on from hospital-based care, either back home or into a care home, nursing staff from Cairnie House remain in contact with the new care team to ensure the discharge is supported and is sustainable. We were told this 'outreach model' had been successful and was valued by relatives and care home staff.

Care records

Information on patients care and treatment was held in the 'MORSE' electronic record system. The change from paper to electronic records has been recent, however we heard that staff have found the transition to be straightforward. We found patients' records easy to navigate, with a clear focus upon an individual's mental and physical well-being.

We were pleased to see risk assessments were reviewed regularly and amended as necessary. We were told the ward had a number of laptops available for nursing staff to use in order to update records in 'real time'. We are aware that the transition from written to electronic records may take some time to bed-in, however we would like to have seen more detail of daily contact sessions between nursing staff and their patients. This would have enabled us to see how patients are day-to-day, whether they had enjoyed specific activities or had days when they required a higher level of staff support. We discussed this with the leadership team on the day of our visit, highlighting that this would be helpful for staff who may not be familiar with the ward or patients.

Use of mental health and incapacity legislation

On the day of our visit, six of the nine patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). There was evidence nursing staff made efforts to support patients in understanding their rights in relation to the Mental Health Act, however for some patients who have significant impairment of their cognitive functioning, their understanding of their rights and restrictions may be difficult to communicate or understand. An advocacy service is available to support patients; nursing staff can initiate referrals on behalf of patients. Advocacy will attend the ward and support patients in relation to Mental Health Tribunal for Scotland hearings, with support being extended to carers and relatives.

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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication that had been 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.

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). We heard about the future 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.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI 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 found that section 47 forms were in place where required.

Rights and restrictions

Cairnie House operates 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 advance statements. The term 'advance statements' refers to written statements made under sections 274 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. The majority of patients in this ward 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

We were aware that during the Covid-19 pandemic, restrictions put in place meant that various activities had to be put on hold, including restrictions placed on the number of visitors to the ward. To ensure families and friends were able to keep in touch with relatives iPads were purchased. Now that restrictions had been relaxed, patients are once again able to see their relatives in the ward environment.

We heard that there has been an emphasis on ward-based activities. There was an activities co-ordinator who provided either one-to-one sessions for patients, or group activities for those who enjoyed the company of others. Unfortunately, the activities co-ordinator post was shared between three wards, therefore their input was limited. However, the ward team value this role and would appreciate a full time ward-based coordinator in the future.

In keeping with the Newcastle model of supporting patients with dementia and related conditions, there is recognition that engaging in therapeutic and recreational activities is essential; supporting patients to engage in interests and hobbies was clearly an aim for the team. Each patient had a timetable of activities they were particularly keen on, with staff providing support and engagement as an aid for promoting mental and physical well-being. This model of therapeutic engagement has also contributed towards the reduction in the use of pharmacological interventions. Staff have noted the benefits of administering fewer medications and there has been a reduced occurrence of falls and in medication related side-effects.

The physical environment

The layout of the ward consists of shared bedrooms and three single bedrooms, communal sitting areas and an accessible large garden. However, we did not find the ward to be 'dementia friendly'.

Dementia friendly wards provide an environment that meets the needs of patients who may be disorientated, present with stress and distress behaviours and have mobility problems. Two years ago, Cairnie House was identified as an appropriate ward for older adults with a diagnosis of dementia, therefore we would have hoped to see an environment that been adapted to meet the needs of those patients with cognitive impairment. We would have expected to find an environment that takes into account the sensory needs of patients and that included dementia appropriate flooring, lighting, single bedrooms with en-suite bathroom facilities and social spaces for patients to rest or engage in pastimes that were relaxing and homely. Unfortunately, we saw bathrooms that were not fit for purpose, communal areas that were bleak and bedrooms that lacked personalisation.

We asked the leadership team to join us when we were reviewing the environment such was our concern about the bathroom facilities. We agreed there was an urgent need to update bathrooms for the comfort of patients and safety of staff. We were told the leadership team were aware the environment does not meet all of the needs of their patient population and were undertaking costings for improvements across all older adult inpatient services. We have requested regular updates due to the ongoing concerns we have from our recent visits to older adult wards.

Recommendation 2:
Managers should address the environment issues in relation to updating fixtures, fittings, decoration, and maintenance issues.

Recommendation 3:
Managers should ensure that the upgrade programme is regularly reviewed, and attention is paid to maintenance issues that compromise patients' safety and privacy.

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 should address the environment issues in relation to updating fixtures, fittings, decoration, and maintenance issues.

Recommendation 3:
Managers should ensure that the upgrade programme is regularly reviewed, and attention is paid to maintenance issues that compromise patients' safety and privacy.

Service response to recommendations

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

A copy of this report will be sent for information to Healthcare Improvement Scotland.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk