Mental Welfare Commission for Scotland

Report on announced visit to: Dunino Ward, Stratheden Hospital, Springfield, Cupar, Fife, KY15 5RR

Date of visit: 12 January 2023

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.

Dunino Ward is a mixed-sex ward situated in Stratheden Hospital. The age of individuals ranges from 18 to 65 years of age with several patients having been in hospital for a considerable period due to the complex nature of their illness. The focus on Dunino Ward was to provide care and treatment to individuals who required mental health rehabilitation before returning to their communities. Care and treatment was provided by a multidisciplinary team (MDT) who worked with individuals to assess their needs, strengths while also providing practical steps towards recovery. It was appreciated that recovery and rehabilitation for this patient population cannot be hurried; however, with input from the MDT including medical, nursing, psychology and occupational therapists, there was a clear sense of optimism.

We last visited this service on 2 November 2021 and made recommendations in relation to care plan reviews, concerns about the environment, and that staff should ensure that all patients were aware of their rights when they were in hospital. The response we received from the service was provided via an action plan and we have received updates from the service over the past 12 months.

On the day of this visit we wanted to follow up on the previous recommendations and to hear how patients and staff have managed throughout the last year, as we are aware that there are still issues related to the pandemic.

Who we met with

We met with five patients and also reviewed their care records. We also met and spoke with three relatives.

We spoke with the service managers, the senior charge nurse, the lead nurse, psychiatrists, psychologist, pharmacist and occupational therapist.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

Susan Hynes, nursing officer

Graham Morgan, participation and engagement officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with were enthusiastic about the care and treatment they received telling us “this is the best ward, better than anywhere else”, “I feel safe, I know what my next steps are, staff motivate me and are not intrusive”. We heard variable feedback from relatives we spoke with; while some relatives felt the ward-based team were “fantastic”, other relatives felt there could be improvements in relation to communication and were often left feeling they were the last to know of any changes to their relative’s care and treatment. We spoke about communication with senior staff on the day of the visit and how to strike a balance between confidentiality and ensuring family members were given information to keep them informed of any changes.

Throughout our visit to Dunino Ward we saw staff and patients who appeared comfortable in each other’s company, patients and staff appeared in good spirits. The focus on recovery and identifying each patient’s strengths was evident during our conversations with patients and the multidisciplinary team.

The Mental Welfare Commission published Scotland’s Mental Health Rehabilitation wards themed visit report January 2020. We were keen to discuss our recommendations from this report with staff on the day of our visit. This was because we recognised patients who are admitted to rehabilitation wards may have had several admissions to mental health wards over many years. Their physical well-being can be compromised, and life skills may have declined. We were pleased again to find patients in Dunino were provided with care and treatment that focused on their strengths and considered areas of need that required additional support from the multi-disciplinary team. Patients we spoke with were able to inform us of their care and treatment, as well as providing details of the input specifically given to enable them to reach their goals. Furthermore, patients told us they felt involved in their care planning, which was important to them as it felt their participation would improve the likelihood of recovery and discharge back into their community.

During our pre-visit meetings and discussions with the senior management team on the day of the visit, we highlighted our ongoing concerns in relation to patients remaining in hospital when they were considered ready for discharge. On the day of our visit, there were a number of patients who were considered ‘delayed discharges’ and this position remained a source of frustration for patients, their relatives and the clinical team. As part of our 2020 report, we made a recommendation in relation to rehabilitation patients whose discharges had been delayed by over three months, that there should be clear plan for discharge in an acceptable timescale. We recognised this was a nationwide concern and we were provided with information about Fife Health and Social Care Partnership’s ‘Housing Priorities Group’. The remit of this group was to address ongoing issues in relation to securing suitable tenancies and packages of care in the community to meet the needs of patients. We were told with limited appropriate housing, available tenancies including support packages had been difficult to arrange. We appreciate this situation is under regular review and will be seeking updates from the management team in relation to progress. We would propose for patients who, due to the complexities of their needs and requirement for on-going care in hospital for a lengthy

period, should have their circumstances regularly discussed with the MDT and local authority partners, with minutes from meetings accessible to patients, their relatives and filed in the patients' care records.

Recommendation 1:
Managers should ensure patients who have been coded as '100', meaning they have exceptional complex needs which have resulted in delays to their discharge, require their circumstances discussed regularly with partners from health and social care. Those discussions should be recorded, and updates shared with the patient, their relatives/ named person.

We found a broad range of assessments that had informed the patient's care, including medical, nursing, occupational therapy and psychology. From those assessments we saw a clear link between assessed needs and care plans that were person-centred and evidenced patient participation. On this visit, we observed that care plans were not separated in terms of individual needs. While we accept the care plans were person-centred, we would have liked to have seen specific care plans for specific needs, rather than a sense of having a care plan that considered all of areas requiring attention.

While the assessments and care plans had a strong focus on rehabilitation and recovery, there was also well-defined physical health care reviews and interventions. Patients were included in national screening programmes and offered primary care specific appointments to address any issues related to gender or age. We were however concerned to hear many patients were still ordering snacks and fizzy drinks from an online local delivery service. We were aware there was a strong focus on patient's physical health and well-being, however this was likely to be compromised by poor diet along with the health risks of smoking tobacco. We discussed this with senior staff on the day of the visit, as we were aware they offered group work and individual sessions to promote healthy lifestyles for patients. However, with continuing access to a local online 'snack service', promoting healthy lifestyles including healthy meal options will be hindered. We asked staff to consider how they communicate with their patients to include lifestyle and wellbeing advice, both opportunistically and routinely during their day-to-day interactions.

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

We heard psychology input was highly valued by patients and staff. While there was a current limitation to psychology input for every patient, this was being discussed with considerations for increased psychology resource. Psychological formulations are an important part of understanding a patient's journey, they also encourage staff adopt a model of care that is person-centred based upon empathy, understanding and compassion. Patients were offered opportunities for one-to-one work and group work that was specifically targeted to consider patients with shared experiences of mental ill-health.

Multidisciplinary team (MDT)

Dunino had a broad range of disciplines either based there or accessible to them. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and update on their views. This also included the patient, and their families should they wish to attend. It was clear to see from these notes that where a patient had made progress or whether there needed to be adaptations to care plans. Furthermore, each meeting identified care staff who had attended, their role and responsibility for providing interventions to support each patient.

Care records

Care records were held on an electric system 'MORSE'. We found them easy to navigate with care planning, assessments and continuation notes held on the one system. We would like to have seen greater detail in patient's continuation notes, this would have allowed us to see how patients were progressing day-to-day; having a documented subjective and objective narrative would be beneficial, as is it would allow the reader to have a richer understanding of a patient's journey through their rehabilitation. We were aware patients had individual activity programmes and one-to-one sessions with their nursing keyworker.

Use of mental health and incapacity legislation

On the day of our visit, 13 of the 19 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act 2000 (AWIA) was in place in the paper files and up to date. The patients we met with during our visit had a good understanding of their detained status, where they were subject to detention under the Mental Health Act and if there was a guardianship order in place under the AWIA, they also knew what this meant for them.

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.

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. Where a patient had nominated a named person, we found copies of this in the patient's file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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 were able to locate completed section 47 certificates and corresponding treatment plane where required.

Rights and restrictions

We were told patients had access to independent advocacy and legal representation. During the pandemic, meetings between patients and their legal representatives or advocacy support workers were largely undertaken by telephone. More recently, legal representatives have met with patients in the ward. Advocacy services had also resumed regular face-to-face meetings with patients, while also offering a telephone service. Ward staff, including mental health officers, provided information about how to access legal representation and support from independent advocacy services. Leaflets and contacts were made available and access to telephones and privacy were encouraged for patients to seek representation during their stay in hospital.

The ward had an 'open door' policy with patients having access to their therapeutic placements in the hospital grounds. Of the patients we spoke to there were a number who were not entirely sure of their rights in relation to the Mental Health Act and the possible restrictions placed upon them. While we appreciate patients were provided with information about how to contact legal representation and advocacy services, it is important for the clinical team to check a patient's understanding of the legal framework in relation to restrictions.

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 a patient 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 reasoned opinions in place.

Our specified persons good practice guidance is available on our website at:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 to 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 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

In the ward environment there was a weekly timetable for therapeutic and recreational activities. Opportunities for group work and one-to-one sessions were available. Staff told us they would prefer to offer additional activities, especially at weekends or in the evenings, however ongoing staff shortages has meant this has not taken place. There was an emphasis on nutrition and providing patients with learning opportunities for meal preparation and improving physical health. Located in the ward was a kitchen for patients to practice 'self-catering'. After the completion of functional assessments, OT's support patients with all

aspects of meal preparation while providing guidance to promote healthy food choices and promote independence. We were encouraged to see the ongoing effort to support patients to think about healthy lifestyles, however this will continue to be compromised if patients were not discouraged from purchasing foods and drinks that have very limited nutritional value.

We looked for evidence of how patients were supported to manage their funds, however we couldn't locate specific documentation for this, and highlighted our concerns regarding this. Various terms can be used for supporting patients with their funds for example 'financial care plan', 'voluntary financial support plan', 'spending plan', or 'budget plan'. Where possible, patients should be given advice and encouraged to manage their own finances with the support of informal use of budget plans.

Recommendation 2:
Managers should ensure patients who require support to manage their funds either formally or voluntarily should be provided with a budget planner.

Over the last 12 months the third floor of the ward has continued to be adapted into a 'therapeutic space' for undertaking one-to-one and group activities. A music room had been included for music therapy sessions, self-care sessions with equipment for staff to provide hand and nail care. An additional room will be used for providing relaxation for individual or group sessions. The ward team have applied for additional funding to purchase equipment to further enhance this therapeutic space, we look forward to seeing how this space continues to develop into a useful resource.

The physical environment

Dunino was a significantly large ward, spread over three floors. It was bright and airy with several communal rooms that had been recently updated with new comfortable furniture. Unfortunately, the ward did appear rather dated in terms of showering / bathing facilities, bedrooms and floor coverings. We were told there had been a request for additional funding to continue with improvements as managers recognised the ward would not be considered fit for the purposes of rehabilitation.

We were pleased to see there had been improvements to the garden as patients and staff had worked together to plant various plants and shrubs and it was now a comfortable space to spend time in. With the addition of new furniture, the garden looked like an inviting space for patients, their visitors and staff.

While the environment may not lend itself to meet the full functions of a rehabilitation ward, it was evident the ward-based team were committed to providing person-centred care that was holistic and empathetic.

Summary of recommendations

Recommendation 1:
Managers should ensure patients who have been coded as '100', meaning they have exceptional complex needs which have resulted in delays to their discharge, require their circumstances discussed regularly with partners from health and social care. Those discussions should be recorded, and updates shared with the patient, their relatives/ named person.

Recommendation 2:
Managers should ensure patients who require support to manage their funds either formally or voluntarily should be provided with a budget planner.

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.

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