Mental Welfare Commission for Scotland

Report on announced visit to:

Elmview and Muirview Wards, Stratheden Hospital, Springfield, Cupar, Fife, KY15 5RR

Date of visit: 20 July 2023

Where we visited

Elmview and Muirview Wards are purpose-built units based on the Stratheden Hospital site. They are bright, modern wards, with uninterrupted views of the countryside surrounding the hospital.

We last visited both wards over the summer of 2022. On that occasion, we were keen to find out whether patients and their relatives had experienced any challenges throughout the Covid-19 pandemic. We were also keen to hear how staff had supported their patients during this difficult time and whether there had been any enduring challenges post-pandemic. During this visit we were pleased to hear both wards had continued to manage through the pandemic and while they acknowledged it was a difficult experience for everyone, there was a keenness to think about the future, both in terms of new initiatives along with building on progress achieved over the last few years.

Both wards support older adult patients. On the day of our visit, Muirview Ward had patients who presented with functional and organic illnesses. Staff had a range of expertise to allow them to support patients who presented with dementia-related diagnosis or patients who were admitted with mental illness, for example, psychosis or mood disorders. Elmview Ward provided continuing care and treatment for older adults who had diagnosis of dementia. The patient population in Elmview Ward presented with varying degrees of cognitive impairment; for some patients they required a more intensive level of support from nursing staff, which could include assistance with personal care, mobility, and dietary needs. For other patients, with a lesser degree of cognitive impairment, staff would support and encourage those patients to maintain their independence as far as possible.

Who we met with

We met with and reviewed the care of 12 patients across both wards. We had the opportunity to hear to the views of six relatives both prior to, and during, our visit to Elmview and Muirview Wards.

We spoke with the clinical nurse manager, senior charge nurses, the lead nurse and the consultant psychiatrist prior to and during our visit to both wards.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

Susan Tait, nursing officer

Gordon McNellis, nursing officer

What people told us and what we found

Patients in Muirview Ward told us they found staff to be “wonderful”, “approachable and non-judgmental”. However, there was a view that while staff were keen to support their patients, this was often compromised due to a lack of resources. In their own way, patients were able to identify a direct connection between reduced nursing resources and the one-to-one support they felt they needed to enable their recovery. For patients in Elmview Ward, we were unable to seek their individual views due to the level of their cognitive impairment, however, during our conversations with relatives, we heard similar views. Relatives appreciated the care and support their relatives received in both wards; however, they recognised that the availability of limited nursing staff in each ward appeared to have an impact upon individualised care and treatment. For relatives who had been providing care at home, having their relative in hospital can be a difficult transition. Relatives told us they needed to feel confident their relative was receiving care that met their individual needs and for some relatives, this was not their experience. They felt staff attempted to work with families, but that communication was, at times, inconsistent and this added to relatives’ concerns about resources in both wards. Due to the number of relatives expressing the same or a similar message, we discussed this with the senior leadership team on the day of our visit. We recognised there were ongoing workforce pressures in all areas of mental health inpatient settings, however, we felt it was important to highlight the concerns raised by relatives and patients.

Care, treatment, support and participation

During our last visit to Muirview Ward we identified several areas where we were keen for improvements to be made. We were pleased to hear that support had been provided by Fife Health and Social Care Partnership (HSCP) quality improvement team with projects that aimed to improve patients’ experience. We were provided with details of several projects that were either underway or ready to begin. We were keen to hear about record keeping standards, person-centred care planning, communication with relatives, and physical health related conditions. During this visit, when we reviewed the care records, we unfortunately found several areas that had yet to be improved upon. As we were aware that both Muirview and Elmview Wards had been working to improve record keeping, we had hoped to see an improvement, but this was not evident in the records we reviewed. We found care plans that we did not consider to be person-centred and that had more of a deficit-based formulation, rather than exploring strengths or skills that could be retained. For this reason, it was difficult at times to determine how progress had been made, or whether specific needs of individuals were identified and how staff would provide interventions to promote recovery or well-being. For patients in Muirview Ward who were able to engage with the process of care planning, they told us they would welcome more one-to-one time with staff. This would create a genuine person-centred model for care planning. For patients who were receiving care in Elmview Ward we understood gathering their views would not be possible, as such was the extent of the cognitive impairment of this patient population. However, where a patient may not be able to participate in their care planning, we would hope staff would invite relatives to participate. We were told this was not always the case and for relatives, having opportunities to work with staff was important to them. We would actively encourage participation from professionals and relatives to support individualised care planning.

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 plans to ensure they fully reflect patients' progress towards stated care goals and that recording of patients' and relatives' input are consistent across all care plans.

Multidisciplinary team (MDT)

Both Muirview and Elmview Wards had input from mental health nursing staff, several of whom have had specific training to support patients with a psychological model of care. This had helped patients, specifically those admitted to Elmview Ward, where patients could present with behaviours that challenge. Having staff who are skilled to support patients who present with stressed and distressed behaviours encourages a whole team model of care and treatment. The wards had input from consultant psychiatrists, an occupational therapist, dietician, and activity support staff. We were told that while referrals to allied professionals are accepted, having dedicated occupational therapists, psychology, and a ward-based activity co-ordinator for each ward would be welcomed. This was a view supported by nursing and medical staff, along with patients and their relatives. It was recognised that having a care team that offered a multi-disciplinary model of care provided patients with bespoke care planning to meet their individual needs, whilst also having professionals providing input aligned to their expertise. We were told recruiting into allied health professional posts had been a challenge. We heard that key staff who were highly valued were due to leave their posts, and recognised that this was likely to have an additional impact upon patient engagement.

Care records

Patients' care records were held on electronic record system, Morse. This was a relatively new system for staff; however, we were told they had found the transition from paper to electronic record keeping straightforward. There were some difficulties including attaching specific paperwork, for example, MDT review meeting minutes. However, for the time being MDT reviews were held in the continuation section of the notes. We found MDT reviews were inconsistent in the level of detail provided from the weekly meeting. We would expect to see a format for each meeting that would include attendance of key professionals, an overview of the week, any progress, actions, and which staff were responsible for completing tasks. Elmview Ward displayed a consistently high standard of record keeping for each MDT meeting. Unfortunately, Muirview Ward MDT record keeping was less well-organised; these would benefit from a format that allowed staff to fully engage with the weekly meeting and a member of the team to undertake the role of minute taker to ensure accuracy of record keeping.

Recommendation 2:
Managers from Muirview Ward should consider a format to capture reviews and minutes from each MDT weekly meeting to ensure accuracy of record keeping.

In the daily continuation notes we would liked to have seen a more detailed narrative. We were aware nursing staff spent a considerable amount of their day engaging with patients, particularly those who required one-to-one care. We would therefore have expected to see a subjective and objective view of how patients and staff interacted, the interventions that had gone well or, when a patient was stressed, how staff supported the patient to feel calm again. The richness of any narrative allows the reader to fully appreciate the care and treatment provided by staff and how this benefitted patients. We discussed evidencing interventions and engagement with the leadership team and wondered whether having a system in place that allowed staff to consistently document the views of patients, while evidencing observations from staff would enhance continuation notes. We were told strategies to improve standards of record keeping will be subject to regular audits of all documentation held in patients' care records. We would hope this audit will help standardise record keeping; ensuring consistent quality while encouraging senior nurses to increase skills and knowledge of more junior staff. This knowledge of accurate and informative record keeping is essential for promoting individualised, person-centred care and treatment.

Recommendation 3:
Managers should consider identifying a system that captures daily contact between staff and patients in their electronic care record.

We were pleased to hear of initiatives that had started around the time of our last visit had become fully implemented in the day-to-day work with patients. With the aim upon reducing risks from falls, there was a focus on medication management and incident reporting, along with a clear focus upon physical well-being. We could see the teams in both wards were keen to consider quality improvement as an embedded ethos in the wards. We heard of future drivers for change to include nutrition and hydration, this was because patients and their relatives had felt the food currently provided by the catering team could, at times, be unappetising. Staff were to undertake an improvement programme to promote personalised meal plans to include dementia specialist food options, dining room environment changes to reduce stress around mealtimes and improving hydration for all patients.

Use of mental health and incapacity legislation

On the day of our visit, several patients were subject to Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) legislation. Of those patients subject to compulsory treatment, we reviewed their legal documentation available in their electronic records.

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 mostly in place. We identified one issue and spoke with medical staff on the day of the visit to ensure errors were rectified.

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 (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. Of the s47 certificates we reviewed, we found several where there was no evidence of consultation with a legal proxy. We discussed this on the day with the senior leadership team as the number of certificates granted without discussion between legal proxies and clinical staff was significant. We advised that regular audits would support concordance with the AWI Act code of practice.

Recommendation 4:
Managers should ensure welfare proxies are consulted with prior to the completion of s47 certificates and completed s47 certificates have an accompanying treatment plan.

For patients who had covert medication in place, not all appropriate documentation was in order, we would expect to find reviews to ensure covert medication was deemed necessary. The Commission has produced good practice guidance on the use of covert medication at: https://www.mwcscot.org.uk/node/492

Recommendation 5:
Managers should ensure there are reviews of all patients subject to covert medication, that relevant documentation is completed and stored securely in the patient's care record.

Rights and restrictions

Both Elmview and Muirview Wards continued to operate with a locked door, commensurate with the level of risk identified with the patient group. A locked door policy was in place.

When we reviewed patients' files, we looked for copies of advance 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 Elmview Ward and a number in Muirview 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. During our meetings with patients, there were several who were not confident they knew about their detention status either under the Mental Health Act or AWI Act. To this end, we asked staff to ensure patients are reminded of their legal status.

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 recognised the importance of therapeutic and recreational activities as we heard from patients and their relatives that they valued the interactions they had with staff, either one-to-one, or in small groups. Having a dedicated member of the team that can invest time and energy into activities with patients had yet to happen. Currently, the activity coordinator is shared between three wards and, with competing demands, they were unable to provide increased support for patients in creating a bespoke activity timetable. Furthermore, without

a dedicated occupational therapist to also engage with patients, both in relation to therapeutic individualised engagements, and group work, there was a sense that patients were not provided with opportunities that could enhance their admission to hospital or maintain skills to reduce the risk of further decompensation.

We were disappointed with the lack of progress with having a detailed, imaginative programme of activities provided by a coordinator for each ward. We recognised this as an important part of a patient's well-being and would offer opportunities to learn new skills and socialise with peers; for staff it would be an opportunity to provide therapeutic engagement.

Recommendation 6:
Managers should review activity provision for Muirview and Elmview Wards to ensure patients are provided with regular therapeutic and recreational activities.

The physical environment

Both wards benefitted from being spacious, with large communal areas and opportunities for relatives to visit and spend time in the gardens of the wards, as the climate allows. All bedrooms were en-suite, with room for patients to have personal items should they wish. We were pleased to see Muirview Ward had opened the doors giving access to the gardens and patients had unrestricted access throughout the ward, which had been limited during our last visit to the ward.

On entering the wards, it was clear there had been a significant effort to ensure both wards were bright, well-maintained, and comfortable for their patients. Bedrooms had been personalised, and sitting areas had been designed to ensure the uninterrupted views of the countryside were captured. To help patients who may be feeling distressed or anxious, there was a quiet sensory room in Elmview Ward; this allowed nursing staff and patients to sit with each other in private. Patients could be 'pampered' and given time to relax.

For individuals who preferred being outdoors, there were large secure gardens with an array of seating for socialising with staff and visitors, or just enjoying the quietness of the garden. With raised beds and plans for re-vamping all outdoor spaces, we are looking forward to seeing the updates staff had envisaged over the next few months. In Elmview Ward there was a sitting room design that had 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 in their early adult years. Muirview Ward benefitted from having a door that separated the ward into two units, which was kept open, meaning patients had the opportunity socialise in an environment that felt less restrictive.

While both wards could accommodate in the region of 20, or sometimes more than 20 patients, we were concerned with limited nursing and allied health care professionals available that the current bed capacity could be considered as too high. We heard from staff that the wards could, and often did, reach the threshold of how staff could effectively provide the care, treatment, and attention each patient required. This was a source of frustration for staff as they endeavoured to provide care that was person-centred, however, felt that this could be hindered due to staffing resources.

Recommendation 7:
Managers should give consideration to current and maximum bed numbers in both wards, particularly with reference to staffing resources.

We were concerned that neither ward had adequate signage. This was particularly important for Elmview Ward, where patients were admitted with dementia and cognitive impairment conditions. Patients were often disoriented and confused, so with little or no signage, it would be difficult for patients to find their own bedrooms, bathrooms or sitting areas.

Recommendation 8:
Managers should ensure Muirview and Elmview Wards have appropriate signage in place to support patients who require assistance with orientation in their environment.

Any other comments

During our visit to both wards we heard from patients and their relatives that staff were keen to support patients and their families. However, this was regularly hampered by the nursing teams' competing demands and a consistent lack of resources. We met with the leadership team, who were equally concerned and frustrated about the shortfalls within the current workforce and were attempting to encourage registered nurses to join their older adults inpatient services. We wish to acknowledge the commitment from staff who were supported by the Fife HSCP quality improvement team. It was clear that staff were committed to improve the patient experience in both wards and that they will endeavour to fulfil their strategies for progressing with their initiatives; this will equally provide staff with learning opportunities to ensure they are equipped with the requisite skills and knowledge.

Summary of recommendations

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Recommendation 2:
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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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