Mental Welfare Commission for Scotland

Report on unannounced visit to: Muirview Ward, Stratheden Hospital, Springfield, Cupar, Fife, KY15 5RR

Date of visit: 25 July 2024

Where we visited

Muirview Ward is purpose-built unit based on the Stratheden Hospital site. It is a bright, modern ward with uninterrupted views of the countryside surrounding the hospital. On the day of the visit to Muirview Ward, there were 23 individuals receiving care and treatment.

Older adults admitted to Muirview Ward had a range of mental health diagnoses and presentations. There were several people who had a diagnosis of functional mental ill-health, the rest of the group had a diagnosis of dementia and related cognitive impairment. It was recognised having a mix of people admitted to the ward with both a functional and dementia diagnoses was not ideal. While the team were able to adapt their nursing skills to meet the needs of individuals, it was recognised sharing an environment could be challenging.

We last visited this service in July 2023 on an announced visit and made recommendations on several areas including care records, person-centred care planning, weekly recording from multi-disciplinary team meetings, regular reviews to take place and be recorded in care records and evidencing the information held in daily continuation notes.

We also made a recommendation in relation to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act), to identify where welfare proxies had been consulted prior to the completion of a s47 certificate and to ensure all s47 certificates had an accompanying treatment plan.

For several individuals who accept treatment through a covert medication pathway, we were unable to find regular reviews. We highlighted the lack of signage, and as individuals who presented with dementia and related conditions were often disoriented in the ward, having appropriate signage to identify rooms would have been beneficial.

Finally, we raised concerns about the lack of activity provision as the ward had been without a dedicated activity coordinator. We recognised this provision was highly valued, a view from staff, individuals and their relatives.

The response we received from the service included a detailed action plan with timescales for the ward-based team to work towards and actions to be completed.

Who we met with

We met with, and reviewed the care of 10 people, 10 who we met with in person, and reviewed the care notes of six. We also met with one relative; we advised the ward-based team we would be happy to contact relatives as we recognised the visit was unannounced and relatives would not have been informed prior to the visit.

We spoke with the service manager, the senior charge nurse, the lead nurse and consultant psychiatrists, including the lead psychiatrist for older adult services.

Commission visitors

Anne Buchanan, nursing officer

Gordon McNellis, nursing officer

Denise McLellan, nursing officer

What people told us and what we found

On the day of the visit to Muirview Ward, those we met with told us that nursing staff were helpful and kind. One person told us nursing staff were “magnificent” and “I have everything I need and more in this ward”. Everyone we spoke to recognised nursing staff had many competing demands with few resources.

This meant that while individuals were positive about their care and treatment, they also felt having more nurses would be beneficial. This was a recurring theme throughout our conversations with individuals and their relatives. Nevertheless, while limited nursing numbers were identified as a cause for concern, individuals were keen to express their gratitude towards the ward-based team and their determination to support individuals and relatives.

Care, treatment, support and participation

When we last visited Muirview Ward we raised concerns in relation to care planning, particularly the lack of evidence to suggest care plans were individualised.

We were pleased to find that for this visit, there had been improvements in this area. We found care plans to be person-centred with evidence of input from individuals and their relatives. We could see where care plans had identified specific needs of individuals, and the interventions required to support them to achieve agreed goals. We recognised where an individual presented with cognitive impairment, their ability to fully inform staff of their needs may be difficult. Nevertheless, we could see where nursing staff had attempted to engage with individuals and their relatives to ensure care plans were individualised. For individuals who were able to communicate their goals to enable recovery, this was demonstrated throughout their care records, including in their care plans.

Multidisciplinary team (MDT)

The ward-based team typically comprised of medical and nursing staff. We were told allied health professionals provided input however, there was not a dedicated occupational therapist (OT). We recognised that while available through referral, occupation therapy was not routinely available. OTs have a valuable role in older adult wards; their specific expertise can support individuals and staff to achieve goals identified through detailed functional assessments. We were told recruitment to allied health professional posts had remained a challenge and was a continued source of frustration for the ward-based team. Nevertheless, where an individual required input from an allied professional such as occupational therapy, dietician, physiotherapy or speech and language therapy, referrals could be made and were accepted usually without unreasonable delay.

Several nurses had undertaken additional training to support individuals who presented with stressed and distressed behaviours often seen with people who have

a diagnosis of dementia and related conditions. The 'Newcastle Model' invites ward-based staff to consider the reasons why an individual may be anxious or present with behaviours that challenge.

With an understanding of an individual's past life experiences and appreciating communication may be compromised due to symptoms of cognitive impairment, the ward-based team have worked together to deliver a psychological model of understanding and gentle curiosity. We were told while nursing staff had become accustomed to working with this model, the training has been extended to members of the MDT including medical staff, healthcare support workers and allied health professionals. Psychology had delivered training previously and have been enthusiastic to have a workforce that are trauma informed. This keenness to extend training had been welcomed by senior medical staff who had recently completed their own training to ensure the model was embedded in the ward.

The MDT met weekly. This meeting charted progress over the week and information from the meeting was held in the individual's care record. We made a recommendation at our last visit in relation to recording information from the MDT meeting as at that time, we were unable to identify any progress or discussion about an individual's care and treatment. We were pleased to find there had been improvements with the recording of MDT meetings, the attendees and their role. We were able to identify where progress had been made and considerations for future discharge planning.

The ward-based team worked closely with the discharge co-ordinator. This role had specific responsibilities and was viewed as a valuable resource to enable liaison with community-based services and the local authority. On the day of the visit, there were three individuals in Muirview Ward that had been identified as having their discharge from hospital delayed. We were told that delays with discharge were typically in relation to finding community placements, identifying suitable care homes or where an application for welfare guardianship was to be heard and finalised in court before discharge arrangements could be confirmed. It was recognised that having a discharge co-ordinator was a helpful link between services and had meant discharge pathways were easier to organise due to improved communication.

Care records

Care records were held on MORSE, an electronic record system that has been in use for around two years in older adult wards. In the daily continuation notes we would like to have seen a more detailed narrative. We were aware nursing staff spent a considerable amount of their day engaging with individuals, particularly those who required one-to-one care. We would therefore have expected to see a subjective and objective view of how individuals and staff interacted, the interventions that had

gone well or when an individual was stressed, how staff had supported them to feel calm again.

The richness of any narrative allows the reader to fully appreciate care and treatment provided by staff and how this benefitted individuals and their families. We discussed evidencing interventions and engagement with the leadership team again, as we had previously brought this to the attention of the senior leadership team on our previous visit to Muirview Ward. We were therefore disappointed to find little progress with documentation, particularly as we were told regular audits would be undertaken to ensure a consistent approach to record keeping.

Recommendation 1:
Managers should ensure audits identified to measure outcomes should be fit for purpose and, if not should be replaced with an audit tool that meets the specific function of a reliable audit tool.

Of the care records and continuation notes we reviewed, we found perfunctory language used to describe individual's presentation, for example, "low profile", "not offering any complaints", "settled" and "accepted medication" For individuals who have advanced cognitive impairment, their ability to engage in conversation may be a challenge. However, for individuals who presented with functional mental ill-health we would expect to find evidence of where nursing staff had made efforts to invite individuals to participate in their care and treatment, seek their views and document those throughout the individual's care records.

Recommendation 2:
Managers should ensure staff are provided with planned time and opportunity to document consistent detailed information in care records.

Use of mental health and incapacity legislation

On the day of our visit, seven individuals were subject to Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) legislation. Of those individuals 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 people, 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 being prescribed.

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.

During our last visit to Muirview Ward, we found discrepancies and made a recommendation for managers to put in place a governance system to ensure s47 paperwork was in order. We reviewed all section 47s and found on this occasion all certificates were in place, with accompanying treatment plans.

For those people that were subject to AWI Act legislation, we found paperwork relating to welfare guardianship was in place and easily located. Staff were familiar with the legal framework and understood their responsibilities to ensure welfare guardians were consulted in respect of the powers granted in individuals' orders.

During our last visit to Muirview Ward we made a recommendation in relation to regular reviews for individuals subject to covert medication pathways. We were pleased to find on this visit that individuals who were subject to a covert medication pathway had all appropriate documentation in place, with evidence of regular reviews.

Rights and restrictions

Muirview Ward continued to operate with a locked door, commensurate with the level of risk being managed in this ward. A locked door policy was in place.

When we review individuals' files, we look for copies of advance statements. The term advance statement refers to written statements made under section 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.

As we have previously noted, there were many people in Muirview Ward who would be unable to write their own advance statement. Nevertheless, to ensure individuals are supported to participate in decisions, nurses should be able to evidence how they have made efforts to enable people to do this and that the rights of each individual are safeguarded.

During our conversations with individuals, there were several who were not confident they knew about their detention status either under the Mental Health Act or the AWI Act. To this end, we asked staff to ensure individuals were reminded of their legal status.

The Commission has developed *Rights in Mind*[1]. This pathway is designed to help staff in mental health services to inform individuals of their rights in respect of

[1] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

compulsory treatment or as a person in hospital informally, without a legal framework in place.

Activity and occupation

We recognised the importance of therapeutic and recreational activities, and we heard from individuals 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 could invest time and energy into activities with individuals had yet to happen.

At the time of our visit, the ward was without a dedicated activities co-ordinator. The post had not been recruited into since our last visit to Muirview Ward. Furthermore, without a dedicated occupational therapist to also engage with individuals, both in relation to therapeutic individualised engagement and, group work, there was a sense individuals 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 in having a detailed, imaginative programme of activities provided by a co-ordinator for the ward. We recognised this as an important part of any admission to hospital that would offer opportunities to learn new skills and socialise with peers; for staff it would be an opportunity to provide therapeutic engagement. We were told by individuals and their relatives that having an organised programme of activities would relieve a sense of boredom, a day spent in hospital could feel very long, particularly if visitors were unable to spend extended periods in the ward.

Recommendation 3:
Managers should consider making provision for an activity co-ordinator in the ward's nursing establishment to ensure individuals' experience of ward-based care is enhanced through therapeutic occupation.

The physical environment

Muirview Ward was a bright, well maintained modern ward with several communal areas along with a dining room and quiet spaces overlooking the countryside. The ward was spacious, and benefits from having large communal areas for individuals to socialise and undertake recreational activities with staff.

All bedrooms were en-suite with options to have personal items to help individualise bedrooms. We were pleased to see Muirview Ward had opened the ward internal doors, giving access to outdoor space and individuals had unrestricted access throughout the ward

We were keen to see the outdoor space, particularly the garden areas as we were told during our last visit that the gardens were not used as often as staff and individuals would like, due to the ground/flooring considered a trip hazard/falls risk. We were disappointed to note the work expected to be carried out to reduce potential risks for people had not happened. We were told by the senior leadership team that there were ongoing difficulties securing funding and a company to carry out landscaping and remedial work to ensure all outdoor space were accessible and safe.

The gardens which could be accessed from various points in the ward were not routinely in use. During warmer weather this would have been considered invaluable and could have offered opportunities for additional therapeutic activities.

Recommendation 4:
Managers should ensure access to outdoor space is accessible for all individuals in Muirview Ward. Remedial work should be considered as a matter of urgency to ensure individuals with mobility issues or cognitive impairment are not compromised and are provided with a safe outdoor space.

Muirview Ward could accommodate in the region of 20, or sometimes more than 20 individuals. We were concerned with limited nursing and allied health professionals available; the current bed capacity could be considered as too high. We heard from staff that the ward would, and often did, reach the threshold of how staff could effectively provide the care, treatment, and attention for each person. 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 5:
Managers should consider current and maximum bed numbers in Muirview Ward, particularly in reference to diagnosis of individuals and staffing resources.

During our last visit to Muirview Ward we were concerned about inadequate signage for individuals to assist with orientation. Again, we observed the ward to be lacking in visible signage. We would suggest this is essential for individuals who have a diagnosis of dementia or cognitive impairment. We brought our concerns to the senior leadership team as we believed suitable signage would have been put in place following our recommendation from our last local visit report.

Recommendation 6:
Managers should ensure visible signage is put in place as a priority to assist individuals with orientation in and around the ward.

Any other comments

We heard similar themes from individuals, relatives and nursing staff of their ongoing frustrations in relation to the limited time the ward-based team could spend with individuals. We were told by individuals that they appreciated the care they received however, with ongoing competing demands on nursing staff, there was a consistent view that staff were unable to undertake all of their duties due to resource issues. Furthermore, individuals admitted to the ward with a range of diagnoses meant staff were required to constantly adapt their nursing skills to meet the needs of many people rather than providing specialist care and treatment. Nursing staff along with individuals valued the expertise of allied health professionals. We were concerned that the lack of provision of occupational therapy and a dedicated activities co-ordinator could result in nursing staff having to extend their role at the possible expense of their own expertise in nursing care.

Summary of recommendations

Recommendation 1:
Managers should ensure audits identified to measure outcomes should be fit for purpose and, if not should be replaced with an audit tool that meets the specific function of a reliable audit tool.

Recommendation 2:
Managers should ensure staff are provided with planned time and opportunity to document consistent detailed information in care records.

Recommendation 3:
Managers should consider making provision for an activity co-ordinator in the ward's nursing establishment to ensure individuals' experience of ward-based care is enhanced through therapeutic occupation.

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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. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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