Mental Welfare Commission for Scotland

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

Date of visit: 22 August 2024

Where we visited

Elmview Ward is an 18 bedded, mixed-sex unit with all bedrooms having en-suite facilities. On the day of our visit there were 18 individuals receiving care in the ward.

The unit provides continuing care and treatment for older adults who have a diagnosis of dementia. Individuals present with varying degrees of cognitive impairment; for some people, they require a more intensive level of support from nursing staff, which can include assistance with personal care, mobility and dietary needs. For others, with a lesser degree of cognitive impairment, staff will support and encourage those individuals to maintain their independence as far as possible.

We last visited this service in July 2023 on an announced visit and made recommendations on several areas that included care planning. We proposed the need for regular audits to ensure care plans were person-centred and evidenced where possible the views of relatives and carers. Recording in continuation notes lacked evidence of one-to-one conversations between staff and individuals receiving care.

We also highlighted the lack of recreational activity provision in Elmview Ward. We were aware the ward had a dedicated activity coordinator who had left their post and with the post not being recruited into, individuals in Elmview Ward had been left without a valued and necessary provision. We had made recommendations in relation to Adults with Incapacity (Scotland) Act 2000 (AWI Act), specifically authorising physical health treatment with a Section 47 certificate. Furthermore, where an individual receives medication as authorised by covert medication pathway, this framework requires the ward-based team to regularly review the need for this authorisation to ensure it remains necessary.

Lastly, as Elmview Ward typically admits people with significant cognitive impairment, we would have expected clear and identifiable signage for all rooms in the ward.

On our last visit, this had not been in place therefore, it was necessary to highlight this to managers. In response, we received a detailed action plan from the service and regular updates throughout the year.

Who we met with

We met with, and reviewed the care of five people, four who we met with in person and five who we reviewed the care notes of. As this visit to Elmview Ward was an unannounced visit, we did not have the opportunity to meet with relatives however, we have had the opportunity to hear from one relative who was keen to write to us with their views of the ward and their relative’s care. We also asked for the ward-based staff to pass on our contact details should any relatives wish to speak with the Commission about their experiences of ward.

We spoke with the service manager, the senior charge nurse, the lead nurse and consultant psychiatrist. We also had the opportunity to meet with the head of nursing at the end of the day feedback meeting.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

What people told us and what we found

Individuals who were admitted to Elmview Ward would typically have had an admission to the assessment ward based on the Stratheden Hospital site. Following a period of assessment that was undertaken by a multidisciplinary team (MDT), individuals were transferred to Elmview Ward for continuing care and treatment, as their needs had been assessed as requiring a higher-level support from nursing staff.

While the majority of individuals were older adults, there were a number of people who had developed dementia at a younger age. The ward-based team recognised this could be extremely difficult for families and made every effort to ensure individuals and their families were supported through their relative's journey. The team provided information and advice in relation to understanding dementia-related illnesses in the younger age group.

We spoke with people who were considered to be in a younger age group. We were told that while they felt "content" in the ward, they recognised there was a noticeable age gap and that was rather difficult in terms of communication. We heard the ward-based team were "kind", that individuals "enjoy the time spent with staff", particularly with opportunities to have fresh air and companionship in the newly refurbished garden.

We were able to observe staff who appeared confident during their interactions with individuals while providing gentle encouragement to undertake exercise and social activities with peer groups.

Throughout our visit we saw interactions between staff and individuals which were warm, good-natured and relaxed. We saw staff taking their time with their communication with individuals. There was a sense of calmness; staff we spoke to felt it was important the people in their care felt safe and secure in light of how symptoms of dementia can sometimes cause individuals to feel disoriented and distressed.

Care, treatment, support and participation

The clinical team have maintained a model of care that included risk assessment tools and interventions to consider individuals who may be at risk of falls or physical health deterioration due to the nature of their illness.

The multidisciplinary team met weekly to review individual's presentations. Included in those reviews were; prescribed medication, physical health monitoring, including blood pressure, screening for infections, dietary/fluid intake and any issues related to movement and mobility.

Adaptations to care and treatment plans were undertaken in a timely manner to ensure any issues were highlighted and managed, to improve outcomes for

individuals. We were told this model continued to provide evidence of improvements, with a significant reduction in falls and related physical complications.

The ward-based team were supported by a quality improvement practitioner and monthly updates were provided to ensure progress was maintained.

Along with focusing upon individual' physical health care needs, the nursing staff worked with a model of care that specifically supported individuals who presented with stressed and distressed behaviours. The Newcastle Model provides a more psychological approach to understanding individual's behaviour. Both nursing and medical staff had attended additional training in relation to the Newcastle Model to promote a team approach to care and treatment. To further assist staff and individuals there was an aim to recruit psychologists to embed this model in the older adult wards across the Stratheden Hospital site.

While there had been challenges recruiting into allied health professional posts, for example occupational therapy (OT), the ward was able to access this service when required. Occupational therapists are a valuable resource, as their functional assessments and accompanying care plans provide strategies to support individuals and maintain a degree of independence where possible.

We reviewed individual's care plans and found there was evidence of a person-centred approach with information gathered from individuals and members of the multidisciplinary team. There was evidence of regular reviews and it was noted who would be supporting the individual, what interventions were required and with the attention towards physical well-being, the care plans lent themselves to a holistic approach to care and treatment.

We would have liked to have seen evidence of how relatives were invited to add their views in relation to care and treatment. We know the team have engaged with an 'open dialogue' approach to communication, having evidence of where relatives have engaged in care planning would be invaluable.

Recommendation 1:
Managers should ensure relatives views about care and treatment should be sought and provide opportunities to have those views included in care plans where possible.

Care records were held in MORSE which is an electronic record system that had been in use for around two years in older adult wards.

In the daily continuation notes we would like to have seen a greater detailed narrative. We were aware nursing staff spent a considerable part 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 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 were disappointed to find language in care records that could be considered perfunctory, for example we saw regular descriptions such as 'low profile' or 'appears settled.' While we accept this may be the objective view of staff it would have been helpful to have a fuller description of an individual's presentation throughout the day.

This can be particularly noticeable for individuals who experience 'sundowning syndrome' where the individual can present with increased confusion and disorientation in the late afternoon and early evening and is largely associated with people who have a diagnosis of dementia. While we reviewed care records, we were also disappointed to see language that was rather critical in nature. This did not appear to be in-keeping with the model of care and treatment the ward-based team had adopted.

Recommendation 2:
Managers should undertake regular audits of care records to ensure all written communication meets the Nursing and Midwifery Council standards for record keeping.

Multidisciplinary team (MDT)
The ward had a MDT of nursing staff and psychiatrists, with access to physiotherapy, dietician and speech and language therapy by referral.

On the day of the visit there was limited OT and psychology provision available to individuals placed in Elmview Ward. We were told recruitment of OT and psychology posts had been difficult and was considered a long-standing issue. We appreciate this frustration, as it is recognised occupational therapy offers many benefits for older adults who present with cognitive impairment. From functional assessments to therapeutic activities, OTs play an important role in the multidisciplinary team.

We are also aware psychology provide a framework for understanding an individual's psychological response to a diagnosis of dementia. Support to understand behaviours that can often challenge is deemed to be essential to promote a person-centred model of care. We have asked to be updated with recruitment into allied health and psychology posts. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the MDT meetings and provide an update on their views. This also included the individual, where possible and their families. From reviewing MDT meeting notes, we

could see that where an individual was moving towards a transfer of care, for example, to a care home, that links were established and maintained throughout the process.

We discussed whether there were any individuals currently in Elmview Ward that would be considered delayed in the timescale for discharge. We were told there was an individual currently considered as ‘delayed discharge’. We heard that where there were delays in relation to locating suitable accommodation, including in a care/nursing home or with a package of care to facilitate discharge back into the community, this caused a sense of frustration for carers and the ward-based team.

A senior nurse had been appointed into a discharge coordinator post to specifically liaise with local authority teams, care homes and colleagues from Fife Health and Social Care Partnership. This liaison role had assisted with communication between community and in-patient services. There were regular meetings to ensure individuals who were considered delayed discharges from hospital were discussed and updates communicated to all services and individual’s families. The discharge coordinator role was highly valued and had considerably benefitted individuals transferring from hospital-based care into their new placements.

Use of mental health and incapacity legislation

On the day of our visit, seven people of the 13 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act). Individuals we met with during our visit had a limited understanding of their detained status. This was in part due to their cognitive functioning related to their diagnosis of dementia. Of those individuals who were subject to Mental Health Act legislation, they were supported by staff and independent advocacy services to ensure safeguards were in place.

All documentation relating to the Mental Health Act, including certificates around capacity to consent to treatment, were in place in the electronic files and were up to date. 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. We found that all T3 certificates which had been completed by the responsible medical officer to record non-consent were available and up-to-date.

If there was a guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (the AWIA), staff were clear on what this meant for individuals. We were unable to locate three copies of welfare guardianship orders for individuals receiving care and treatment in the ward. We asked for those copies to be included in individual’s files to ensure the ward-based team have a record of welfare and financial powers currently in place.

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. Where this was required, we could not always locate where a proxy had been consulted. We brought this to the attention of medical staff and senior leadership team on the day of the visit. This is the second time we have identified this issue and requested staff undertake regular audits to ensure section 47 certificates comply with the legal framework.

Recommendation 3:
Managers should ensure welfare proxies are consulted prior to the completion of section 47 certificates and signatures of agreement are in evidence on the certificate.

We found 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms in individual's files we viewed, with anticipatory care plans also in place. We saw confirmation of the involvement of relatives in decision-making in relation to these documents.

For individuals who had covert medication in place, all appropriate documentation was in order, and records of reviews were in place.

Rights and restrictions

Elmview Ward continued to operate a locked door, commensurate with the level of risk identified in the population of the ward.

When we are reviewing individual's files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 previously noted, the majority of people in this unit 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.

Activity and occupation

We recognised the importance of therapeutic and recreational activities as we heard from individuals 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. The ward was

without a dedicated activities coordinator, with the post not being recruited into since our last visit to Elmview 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 coordinator for the ward. We recognised this as an important part of any admission to hospital and would offer opportunities to learn new skills and socialise with peers; for staff it would be an opportunity to provide therapeutic engagement. We could see where staff were taking time to offer activities however, with competing demands of the ward there was little in the way of a consistent, predicable scheduled activity programme.

Recommendation 4:
Managers should endeavour to support the recruitment into activity coordinator posts for older adult services, either within current staffing establishment or through additional funding.

The physical environment

On entering the ward, it was clear there had been a great amount of effort to ensure the ward was bright, well maintained and comfortable for everyone.

Bedrooms had been personalised, sitting areas had been designed to ensure the uninterrupted views of the countryside were captured. To support individuals who may be feeling distressed or anxious, there were several areas in the ward where people could retreat to and these areas offered a space to relax. We were told new furniture and equipment has been ordered to further enhance the environment.

For individuals who preferred being outdoors, there was a large secure garden with an array of seating for socialising with staff, visitors or just enjoying the quietness of the garden. The garden had benefited from considerable improvements. With raised beds, sensory equipment and opportunities for individuals to participate in developing the space, it had become accessible for everyone to enjoy.

We heard there were additional plans to refurbish one of the communal sitting rooms to reflect the age group admitted to Elmview Ward. There was recognition that people have moved away from post war era, and mid-century decoration and furniture would be more appropriate. We are looking forward to seeing the new features of the ward.

Any other comments

We wish to acknowledge the skill and determination the ward-based team had to deliver person-centred care and treatment. When we visit older adult wards, we are keen to hear how staff engage with individuals who by virtue of their cognitive decline are perhaps not in a position to comment on the care they would wish to receive.

With patience and understanding of an individual's abilities, the team make every attempt to support people while ensuring their safety and dignity. We are aware there are professionals who were not part of the MDT, for example occupational therapy, psychology and activities coordinator. We would imagine if those roles were a substantive part of the ward-based team, the opportunities for engagement with individuals would be significantly enhanced. Nevertheless, even without the benefit of allied health professionals we could see the ward-based team have remained committed to deliver person-centred holistic model of care.

Summary of recommendations

Recommendation 1:
Managers should ensure relatives views about care and treatment should be sought and provide opportunities to have those views included in care plans where possible.

Recommendation 2:
Managers should undertake regular audits of care records to ensure all written communication meets the Nursing and Midwifery Council standards for record keeping.

Recommendation 3:
Managers should ensure welfare proxies are consulted prior to the completion of section 47 certificates and signatures of agreement are in evidence on the certificate.

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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.

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

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