Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 28 September 2023

Where we visited

Cairnie House is a 10-bedded ward for men with a diagnosis of dementia and is based in the grounds of Stratheden Hospital. We last visited the ward in October 2022 and made recommendations in relation to care planning and the need for regular audits to ensure reviews were undertaken and identify patients' progress during their admission. We also made recommendations relating to the environment, and were concerned during our last visit that the Cairnie House environment required significant investment. We asked for an upgrade programme to be regularly reviewed, with attention to be paid to maintenance issues that compromised patients' safety and privacy.

On the day of this visit we wanted to follow up on the previous recommendations and to meet with the senior leadership team from Cairnie House, as there had been several changes to the senior nursing team. We were told the inpatient services for older adults had been working closely with quality improvement (QI) team, with a commitment to have all staff trained in QI, thus leading to improving outcomes for every patient in Cairnie House.

Who we met with

We met with four patients and also reviewed their care. We also met with relatives.

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

Commission visitors

Anne Buchanan, nursing officer

Alyson Paterson, social work officer

What people told us and what we found

We recognise for individuals admitted to Cairnie House, their ability to inform us of their experiences may be difficult, such was their cognitive impairment. However, the patients we spoke with told us they felt "looked after well" that they "felt safe". Relatives told us, "communication had improved, my relative's keyworker is in regular contact", "personal care is good, attention to personal appearance is lovely to see". Patients and relatives told us however that they would welcome the opportunity for more activities. They felt recreational activities would be beneficial and add daily interest in the ward. The environment was also mentioned to us, as relatives felt the ward looked very tired and clearly required updating.

Care, treatment, support, and participation

On the day of our visit there were 10 patients in the ward, which felt calm and quiet, with nursing staff providing care and support for their patients, either individually or socialising with them in small groups. On the day of our visit, we observed interactions between staff and patients which were compassionate, considerate and caring. There was a recognition that this patient population required a high level of support with all aspects of their care and treatment, including with personal care, dietary and fluid intake, social support, and assistance with mobility. Patients appeared comfortable in the company of staff and were typically in good spirits. We were told patients in Cairnie House could display behaviours that could challenge, and these could range from stressed and distressed behaviours to communication difficulties. We were keen to hear how staff supported their patients particularly during times of heightened anxiety.

We were pleased to hear there had been a commitment from the senior leadership team to have all staff, including medical staff to attend 'essential stress and distress' training. We found on this occasion care planning had considerably improved with senior nursing staff supporting junior staff to adopt a model of care that included psychological formulations. Psychological formulations form the basis of understanding a patient's life before their diagnosis of dementia, to identify triggers that could cause stress and distress, and to develop strategies to support individuals in meaningful engagement.

We were pleased to see that in the care plans we reviewed there was a clear focus on including the views of relatives, and where possible, the views of the patient. Additionally, there was input from psychology and allied health professionals in the interventions provided. We recognised having input from allied health professionals was important and while patients had access to psychology, physiotherapy, speech and language therapy and dietician, there was a vacancy for an occupational therapist.

We appreciated that providing copies of individualised care plans to every patient would not necessarily be appropriate due to their cognitive impairment and ability to interpret specific care needs. However, for some patients, sharing a copy of their care plans would be appropriate and help individual patients feel involved with their care. We met with an individual who was keen to have a copy of their care plan and we shared this request with nursing staff on the day of the visit.

Due to the level of cognitive decline and associated physical health comorbidities that can often be found with patients who have diagnosis of dementia, we were pleased to find care

plans with a clear focus on physical well-being. This focus had been supported by Fife Health and Social Care Partnership (HSCP) quality improvement team and had extended to reducing risks from falls, reducing the reliance on medication for the management of stress and distressed behaviours and supporting staff to consider patient safety in all aspects of care and treatment. We were told by nursing staff that having opportunities to review patient care in the ward-based team and having regular audits undertaken had significantly improved the quality of patients' care plans. Of the care plans we reviewed, we found individualised care plans, with goals and interventions that would be considered person-centred.

We would have liked to have seen the daily continuation notes having a clear link between patients' care plans, specifically those relating to stress and distress and how interventions were utilised to reduce patients' distress. Having a descriptive narrative in daily recordings would have allowed the reader to appreciate how the staff supported patients, which interventions were used, and the progress and outcomes that were achieved. We asked the senior leadership team on the day of the visit to consider encouraging staff to record evidence of how interventions from care plans were utilised and to record the outcomes that benefited patients.

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

Multidisciplinary team (MDT)

The MDT met weekly to discuss each patient, with feedback from a range of professionals. There were detailed minutes from each review, actions noted and those responsible for the actions were clearly recorded. There was a new format for capturing information from the weekly meeting, and we asked the team to include who attended the meeting and their discipline, this would assist with identifying which professional had been providing input either into the meeting or would be in the future. There was a recognition that patients admitted to Cairnie House required robust assessments as there were often co-morbid conditions present, including mental ill health and physical health conditions. We saw evidence of assessments that included the 'holistic older adult assessment tool' that considered a range of needs including nutrition, fluid intake, skin integrity, pain and comfort.

We were told that the physical well-being of each patient was a priority as some patients in Cairnie House had communication difficulties and could not always inform staff if they were in discomfort. The focus on this had ensured patients received immediate care in relation to their physical health and had reduced the need for patients to be transferred to medical wards, therefore reducing any stress this may cause to patients. Referrals to psychology and allied health professionals, such as physiotherapy, speech and language therapy, and podiatry were made as required following assessment.

We were told there were several vacancies at present for nursing staff, as well as the ward based occupational therapist. We were told recruiting into this post had been a challenge and while referrals for occupational therapy provision were accepted promptly, nursing staff believed there could be significant benefits for patients from having a ward-based

occupational therapist, not only to undertake a variety of assessments, but also to support nursing staff to work with patients who may require input in relation to activity and occupation.

On the day of our visit there was one patient who was considered as delayed in their discharge from hospital. We were told the discharge co-ordinator had a specific role as a link between local authority teams, care homes and colleagues from Fife HSCP. This liaison role continued to assist with communication between community and in-patient services. There were regular meetings to ensure any patients whose discharge from hospital would be considered as delayed were discussed, with updates communicated with all services and the patient's family. Staff told us they valued the close links they had with patients' social workers and with regular communication this had supported patients' pathways from hospital-based care to community care homes.

Care records

Information on patients' care and treatment was held in the 'MORSE' electronic record system. The change from paper to electronic records had happened over the last year, with most of all paperwork merging onto MORSE. We found information relating to patients' care and treatment easily accessible however, information relating to Adults with Incapacity (Scotland) Act 2000 was difficult to locate, and therefore we suggested there should be copies of documents held both on the electronic record system and paper copy too. This was because ward-based staff were required to know who to contact in relation to welfare guardianship and attorneys, specifically in relation to discussions about care, treatment, and welfare decisions.

We found patients' records easy to navigate, with a clear focus upon an individual's mental and physical well-being. We were pleased to see risk assessments were reviewed regularly and amended as necessary. We were told the ward had several laptops available for nursing staff to use in order to update records in 'real time'. We would like to have seen greater detail of patients' daily engagement with staff, particularly in relation to interventions derived from individual patients' care plans. This would have enabled us to see how patients were day-to-day, whether they had enjoyed specific activities or had days when they required a higher level of staff support. We discussed this with the leadership team on the day of our visit, highlighting that this would be helpful for staff who may not be familiar with the ward or patients.

We also brought to the attention of senior nurses about the use of descriptive language nursing staff had written in patients' care records. We would expect written communication to be objective, considerate, and professional. On occasion we found descriptions of patients' presentations that fell short of the Nursing and Midwifery Council (NMC) standards for record keeping. We saw in continuation records, language that could have been considered pejorative, critical, and judgemental. This appeared to have been out of keeping with the work that had been undertaken by nursing staff to support patients, who by virtue of their illness, often had considerable communication difficulties.

Due to our concern, we spoke with the nursing leadership team on the day of the visit, identified specific record entries, and asked that all staff were reminded of the NMC guidance

for record keeping. Equally, we requested that non-registered staff also be reminded of their own professional requirements to ensure appropriate and professional record keeping.

Recommendation 1:
Managers should ensure all staff who record in patients' care records are provided with guidance to ensure all documentation is appropriate and professional.

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.

Use of mental health and incapacity legislation

On the day of our visit, six of the ten patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). There was evidence that nursing staff made efforts to support patients in understanding their rights in relation to the Mental Health Act, however for some patients who presented with a significant impairment of their cognitive functioning, understanding of their rights and restrictions may be difficult to communicate or understand. There was an advocacy service available to support patients, and nursing staff could initiate referrals on behalf of patients. Advocacy attended the ward and supported patients in relation to Mental Health Tribunal for Scotland hearings, and support could be extended to carers and relatives too.

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 with the medication being prescribed. We found that all T3 certificates had been completed by the responsible medical officer to record non-consent; they were available and up-to-date.

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 must be completed by a doctor. The s47 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. On the day of the visit, we became aware staff would benefit from additional training in relation to AWI Act legislation. It is important for all staff to understand when a s47 is required and in terms of the accompanying treatment plan, what interventions are legally authorised. For this reason, we suggested all staff should undertake eLearning modules that are available to them. These can be located through NHS Scotland TURAS digital platform and are available for all professionals employed in NHS Scotland.

For patients who had covert medication in place, all appropriate documentation was in order, and records of reviews were in place. The Commission has produced good practice guidance on the use of covert medication which can be found at:
https://www.mwcscot.org.uk/node/492

Rights and restrictions

Cairnie House continued to operate a locked door, commensurate with the level of risk identified with the patient group. A locked door policy was in place.

When we are reviewing patients' care records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. Many patients in this ward would be unable to write their own advance 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. We saw evidence that this was happening.

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 7 in their treatment. This can be found at: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

At the time of our visit, Cairnie Ward did not have an activities co-ordinator. The older adult wards had applied for additional funding to support activities provision for each older adult ward based in Stratheden Hospital. While recruitment into these posts was likely to happen soon, the ward-based nursing team were attempting to provide activities for patients either in a one-to-one or in small group. Individual nursing staff were identified each day to provide recreational activities, which ranged from encouraging movement and exercise, music, and crafts. With the recent purchase of equipment specifically for patients with dementia and related cognitive conditions, there had been some improvements in terms of engagement with activities.

The physical environment

The layout of the ward consisted of shared bedrooms and three single bedrooms, communal sitting areas, and an accessible large garden. However, we did not find the ward to be 'dementia friendly'. Dementia friendly wards provide an environment that meets the needs of patients who may be disorientated, present with stress and distress behaviours and have mobility problems. We would have expected to find an environment that considered the sensory needs of patients and that included dementia appropriate flooring, lighting, single bedrooms with en-suite bathroom facilities, and social spaces for patients to rest or engage in pastimes that were relaxing and homely.

Unfortunately, since our last visit there had been very little improvement in the environment. However, we had been made aware a grant application for outdoor space and gardens had been approved with work to start over the next few months. The ward itself was due to have a schedule of work to update fixtures and fittings and re-decoration. New furniture had been purchased with further improvements planned to ensure the ward is a dementia friendly, warm and inviting space for all patients and their relatives. We look forward to hearing of progress and have asked the leadership team to provide regular updates.

Any other comments

We wish to acknowledge the commitment of nursing staff and the leadership team in their efforts to improve patients' experience in Carnie House. We saw the benefits of having close links with Fife HSCP quality improvement practitioners to ensure patient safety and well-being remained at the forefront of patient care and treatment. Moreover, we observed nursing staff who were keen to develop their skills and knowledge to ensure patients received personalised treatment to meet their individual and often complex needs. We are looking forward to our future visits to Cairnie House, to see improvements in the environment and to hear how the multidisciplinary team establishment have developed to include additional occupational therapy and activity coordinator provision.

Summary of recommendations

Recommendation 1:
Managers should ensure all staff who document in patients' care records are provided with guidance to ensure all documentation is appropriate and professional.

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.

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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