Mental Welfare Commission for Scotland

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

Date of visit: 29 January 2025

Where we visited

Dunino Ward is a mixed-sex ward situated in Stratheden Hospital. Individuals in the ward ranged from 18 to 65 years of age, with a number of people having been in hospital for a considerable period due to the complex nature of their illness.

The focus on Dunino Ward is to provide care and treatment for those who require mental health rehabilitation before returning to their communities. Care and treatment was provided by a multidisciplinary team (MDT) who worked with individuals to assess their needs and strengths, whilst also providing practical steps towards recovery. It is appreciated that recovery and rehabilitation for some people cannot be hurried; however, with input from the MDT including medical, nursing, psychology, occupational therapy (OT), there was a clear sense of optimism.

We last visited the service in January 2023 and made recommendations in relation to discharge planning pathways and, that these discussions should be recorded between the ward staff and health and social care partners; those discussions and updates should be shared with individuals and their relatives. We also made a recommendation in relation to individuals having access to budget planners to help manage their own funds.

We received a detailed action plan from the service that outlined who would be responsible for ensuring recommendations would be progressed and specific timelines. We were pleased to hear regular meetings between ward-based staff and community health and social care partners were taking place and those discussions were recorded in individuals' care records.

Who we met with

We met with six individuals and reviewed their care records.

We also had the opportunity to meet with nursing staff, including the lead nurse for rehabilitation services. As this was an unannounced visit to Dunino Ward we did not have the opportunity to meet with relatives on the day of the visit however, we asked staff to provide our contact details should relatives wish to speak to us after the visit.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

People we met with told us staff were “really nice”. For one individual, they considered their experience as being positive, telling us that “Dunino Ward is much better than other wards I’ve been in”, “staff listen to you and I felt involved in my care.”

Furthermore, opportunities to engage in recreational and therapeutic activities was welcomed and while there were some days when actively engaging in activities was difficult, we heard “staff really try encourage you.” For some people who had been admitted to Dunino Ward, there was a source of anxiety around a lengthy admission, and also around living with people with severe mental ill-health, which had at times been difficult. People explained that the ward could be busy, and at times very loud. Staff were available to support individuals however, the unpredictable nature of some of those in the ward did cause concerns for some.

We spoke with nursing staff who had joined the ward-based team, they were enthusiastic about working in Dunino Ward and the opportunities for further development in terms of their knowledge and skills.

Care, treatment, support, and participation

We had the opportunity to meet with the lead nurse for rehabilitation and low secure services. We were keen to hear about the proposed plans for the service and how the current model is likely to change in the future.

We were told there would likely be a reduction in the number of beds available in the current ward. This is because there is an intention to consider a more assertive approach to rehabilitation and access to other available wards on the hospital site. With fewer individuals in each ward, there is a view the MDT would be able to provide a more intensive bespoke programme of rehabilitation. Rehabilitation could then be extended to the community in terms of tenancies and placements. The senior leadership team recognised there will be individuals who require a longer stay in hospital, as their illness is typically complex, and those individuals require a degree of security that requires an ’in-patient’ setting. For those individuals, rehabilitation will still be available however, possibly at a slower pace to accommodate their unique needs.

A review of care pathways is being undertaken which will seek to promote more seamless working between the inpatient and community rehabilitation team. This is seen as a positive step as individuals move back to their communities. Furthermore, the ward currently has supported several individuals to return to the community, which has facilitated admissions into the service for people who have required a period of rehabilitation following their admission to general adult admission wards.

Care records

We had the opportunity to review several care records and meet with keyworkers/named nurses who had been assigned to support individuals with their recovery. While it was evident when speaking with individuals and staff that the model of care in Dunino Ward was to support recovery through rehabilitation, we had some difficultly navigating the care records that were held on three different systems.

Electronic records were held on MORSE. This system held daily progress notes, assessments and some care plans. There were also hardcopy paper records for individuals, along with additional information held in MORSE. We required support from staff to navigate through the records and asked whether this system was a help or a hindrance to staff. We were told the system currently in place was not 'user friendly', somewhat cumbersome, and awkward to use.

Of the care records we reviewed, we could see evidence of a strengths-based model of care. This model was used by several members of the MDT, for example psychology, OT and other allied health professionals, such as physiotherapy and dietetics.

We also heard how Scottish Action for Mental Health (SAMH) had made some positive connections with individuals in Dunino Ward, including helping them across a range of areas that included improving confidence to use public transport, reintegration into local communities and support with transitions from hospital-based care to living independently. This link between community services and the ward has strengthened relationships to support recovery and sustainable discharges from hospital-based care.

We were told there was an intention to re-commence adult education provision back into the ward. This initiative had been welcomed by individuals who by virtue of their early childhood experiences or significant disruption to their education due to mental ill-health, had limited opportunities for learning. Having adult education was deemed to be an essential inclusive step to support individuals back into education.

We found a broad range of assessments that had been undertaken by individual members of the MDT. Of the assessments we reviewed, we could see where there were specific areas that required input from OT, physiotherapy, psychology, and the dietician.

On this visit, we were unable to find a consistent approach to care planning. While we accept care plans should be bespoke and person-centred, we also acknowledge having a framework that invites nursing staff to evidence a reliable approach to goal setting, interventions and reviews would have been beneficial. Understanding how progress had been achieved through regular reviews was also absent in some of the

care plans were reviewed. It was clear through our conversations with staff and individuals that care and support had been an essential part of an individual's recovery however, we were unable to see specific evidence of how this had been achieved, and at times by whom.

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the person's progress towards stated care goals, are reflected in care plan updates and that recording of reviews are consistent across all care plans.

The Commission has published a good practice guide on care plans[1]. 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.

We heard psychology input continued to be highly valued by the MDT and the individuals receiving care and support in Dunino Ward. There had been an increase in psychology provision into the ward, with psychological formulations now part of all individuals' recovery pathway. Team psychological formulations were an important part of the ward's model and ethos. This model has supported staff to appreciate the complexities of early childhood experiences and how those had a possible impact upon an individual's mental well-being. Furthermore, psychological formulations offered opportunities for individuals to work in collaboration with the MDT, to some extent, as equal partners.

During our reviews of care records, we looked at the daily continuation notes typically written by nursing staff. We found some evidence of one-to-one meetings between individuals and their keyworker/named nurse. Unfortunately, this was not consistent or regularly documented in the care records. Where there had been one-to-one meetings we could see where care plans had been discussed, as well as areas of progress identified. However, we would like to have seen a consistent and reliable approach to one-to-one meetings. The possible inclusion of a template or framework could invite a more consistent approach to capturing essential information.

Recommendation 2:
Managers should ensure there is a consistent approach to documenting one-to-one meetings with individuals.

Multidisciplinary team (MDT)
Individuals admitted to Dunino Ward were supported by a range of allied health professionals that included OT, physiotherapy, dietician, and an activities co-ordinator, along with nursing and medical staff and a visiting GP. We were told

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

access to a regular visiting GP had been invaluable. The ward-based team recognised the importance of physical health care, as individuals with severe mental ill-health over many years were at possible risk of compromised physical well-being. Early identification of potential health issues had been a focus for the team and working collaboratively had seen health inequalities in this population reduce.

We were told the MDT met regularly to discuss and review every individual, and there were additional three-monthly reviews that discussed a wide range of areas that included an individual's views in terms of goals, achievements and progress. We found detailed minutes from each meeting, including the three-monthly meetings.

We were told there remained challenges in relation to the allocation of suitable community placements or tenancies for people leaving hospital. The local authority partners, community rehabilitation team, and health and social care teams met regularly to discuss discharge pathways. On the day of the visit to Dunino Ward there were 19 people receiving care and support. We heard that approximately half the individuals in Dunino Ward were considered as 'delayed discharges', meaning that they were deemed to be clinically ready for discharge, but remained in receipt of hospital-based care. The reasons for this were typically due to the allocation of community placements and tenancies, access to suitable support packages and awaiting welfare guardianship applications to be processed. Where possible, there had been successful discharges from hospital-based care. Nevertheless, the ward continued to have a waiting list for people who required rehabilitation and with bottlenecks in the system, this situation is unlikely to alter in the near future.

Use of mental health and incapacity legislation

On the day of the visit, 13 of the 19 individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was in place and accessible on MORSE.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are 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, were in date, and corresponded to the medication being prescribed.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies in their individual files.

In relation to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), where the person had granted a power of attorney (POA) or was subject to welfare

guardianship, this was recorded on MORSE. However, we had difficulty locating copies of the powers on the electronic record system. Having access to the powers granted in the welfare guardianship order and discussions around the delegation of these powers to the ward-based team should be recorded accurately in individuals' care records.

Recommendation 3:
Managers should ensure all paperwork relating to the AWI Act is accessible and available in individuals' care records. Discussion in relation to delegated powers should be identified, agreed and documented in care records.

Where an individual lacks capacity in relation to decisions about their medical treatment, a certificate 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 consult with any appointed legal proxy decision maker and record this on the form. We were able to locate completed section 47 certificates and corresponding treatments plan where required.

Rights and restrictions

We were told individuals in Dunino Ward had access to independent advocacy services and legal representation. Advocacy services received referrals from individuals, staff and visited the ward regularly where they met with individuals. Advocacy services also extended their service to carers and relatives and ward-based staff could signpost and provide contact details for a range of services, including peer carers support groups.

The ward had an 'open-door' policy with individuals having access to their recreational and therapeutic placement in the hospital grounds.

Where an individual had restrictions in place in terms of time off the ward, for example, which related to physical risks or a degree of cognitive impairment, we would have expected there to be a specific risk assessment and support plan in place. We were unable to locate risk assessments or support plans for individuals where restrictions had been put in place.

Recommendation 4:
Where an individual has restrictions in place in relation to time off the ward, managers should ensure there are risk assessments and accompanying support plans to provide evidence of why restrictions are necessary.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is

a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

On the day of the visit, we became aware while reviewing an individual's care records that they had been subject to room searches and person searches. We enquired whether the individual had been designated as a specified person under section 286, which would have legally authorised this intervention. Unfortunately, nursing staff were not able to locate specific paperwork or confirm whether the individual had been provided with information about this restrictive practice, or indeed how to appeal against it.

Recommendation 5:
Managers must ensure that all restrictions being placed on individuals are legally authorised under specified person legislation and proper notification has been given.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[2].

When we are reviewing individuals' files, we look 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. We were pleased to have found individuals had written their advance statements and those were held in the electronic record system.

The Commission has developed *Rights in Mind.*[3] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

There was a weekly timetable for therapeutic and recreational activities. Opportunities for group work and one-to-one sessions were available, and individuals were supported by a range of professionals.

There continued to be an emphasis on nutrition and providing individuals with skills in terms of meal preparation and understanding the importance of weight management.

The ward-based team were keen to improve physical health outcomes for people admitted to Dunino Ward. This is because there was a recognition that people who

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

have a diagnosis of mental illness and who have been in hospital or living in their own tenancies have perhaps not had access to primary care services. Physical well-being was considered essential, with access to national screening programmes being encouraged and staff available to support individuals to attend their appointments.

The ward-based team also recognised rehabilitation for people admitted to Dunino Ward may take a period of time due to the complexities of their illness and social circumstances. The MDT were committed to providing activities that individuals found interesting. There were times where individuals found maintaining motivation particularly challenging. For those individuals, the MDT, and in particular OT put in place specific support plans that set out agreed goals, interventions and outlined achievements.

As part of the process of rehabilitation, individuals may be supported to manage their personal funds and finance. While reviewing care records, we would expect to find care plans that specifically identified where an individual had a budget plan in place. We were unable to locate specific care or supports plans however, we were able to locate an individual's budget plan paperwork. We would like to have seen where assessments had taken place that had identified an individual required a budget plan and how the individual was to be supported to manage their funds and whether they agreed to the budget plan.

Recommendation 6:
Managers should ensure where a budget plan has been agreed to support people with their funds, there is a care plan in place to provide evidence of why this is necessary and proportionate.

The physical environment

Dunino Ward is large and spread over three floors. It was bright and airy with several communal areas and a shared dining room that was also available for recreational and therapeutic activities. There were additional spaces on the second and third floors that provided a self-catering kitchen and small dining room, a therapy space on the third floor.

It was clear that while the ward offered space for communal living, it would not be considered fit for purpose in terms of modern-day standards. There were limited single bedrooms with bathroom/shower room facilities. The ward would be considered dated and while efforts had been made to 'modernise' the ward, there were limitations to this due to the age and fabric of the building itself. We were told that the senior leadership team have recognised that Dunino Ward, in its current condition, needs to modernise. This also extends to the rehabilitation model of care.

We were pleased to hear there were initial draft proposals of how available wards on the hospital site could be used to facilitate reducing the size of Dunino Ward, whilst also offering individuals a more intensive model of rehabilitation. We look forward to hearing of how these proposals progress over the next few months.

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. 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 an individual's care, treatment, and support are 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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