Mental Welfare Commission for Scotland

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

Date of visit: 1 September 2025 and 16 September 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Elmview Ward is an 18-bedded, mixed-sex unit that provides continuing care and treatment for older adults who have a diagnosis of dementia.

Muirview Ward is a 24-bedded mixed-sex admissions unit that provides assessment for people with a functional and an organic mental illness.

On the day of our visit, there were 15 individuals in Elmview Ward with three vacant beds and there were 22 individuals in Muirview Ward with two vacant beds.

We last visited Elmview and Muirview Wards in July and August 2024, respectively, on unannounced visits. We made recommendations in Elmview Ward about record keeping audits, consultation with relatives and section 47 certificates under the Adults with Incapacity (Scotland) Act 2000 (The AWI Act).

We made recommendations in Muirview Ward about recordings in the care record, audits, bed provision, signage and the outdoor space.

We were concerned about the lack of therapeutic activity provision across both wards and made recommendations about this on our previous two visits to both wards in 2023 and 2024.

We also highlighted following our local visits to both wards in 2022 and 2023 that there was one activity co-ordinator in place, that covered the three older adult wards on the Stratheden site. However, we were aware that the post became vacant following our 2023 visit and had not been recruited to since.

We received a response from the service that was outlined in a detailed action plan as to how the service planned to meet the recommendations.

On the day of this visit, we wanted to follow up on the previous recommendations and find out about any impact on individuals experience when admitted to Muirview Ward, as this ward continued to admit people with diagnoses of functional and organic mental illness. In 2019 the Commission carried out a themed visit to older people's functional mental health ward.

Senior managers had notified the Commission in 2024 of the closure of Cairnie Ward that was also on the Stratheden site and we had been told that some individuals had been transferred to other older adult inpatient wards across Fife, including Muirview and Elmview Wards.

Who we met with

In Muirview Ward we met with eight individuals and reviewed the care notes of seven of those people.

In Elmview Ward, we met with four individuals and reviewed the care notes of those four and another two individuals who we did not meet in person.

We met with four sets of relatives in Muirview Ward and four sets of relatives in Elmview Ward.

We spoke with the clinical service manager, clinical lead for old age psychiatry, the senior charge nurse (SCN) in Muirview ward, the charge nurse (CN) in Elmview Ward, ward-based nursing staff, an activity volunteer, the clinical psychologist and the music therapist.

We also met with senior leaders from NHS Fife at our feedback session.

Commission visitors

Tracey Ferguson, social work officer

Denise McLellan, nursing officer

Mary Hattie, nursing officer

Susan Hynes, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

Throughout the day of our visit, we introduced ourselves and chatted with all individuals across each of the wards. In Elmview Ward, we were unable to have detailed conversations with all people, due to the progression of their illness. The CN in Elmview Ward told us that the ward had several younger adults with early onset dementia, and we had noted this on the day of our visit.

Where we were able to have a more detailed conversation, individuals told us that the staff were “nice” and “lovely”. One individual told us that they were “happy” being on the ward and told us that they were waiting on a placement.

Feedback from relatives in Elmview Ward was mostly positive. Relatives described the staff as “dedicated, compassionate, caring and fabulous”. Relatives told us that they met and/or spoke with the psychiatrist regularly and found the updates helpful. Some relatives told us that they had been involved in the care plans whereas others told us that they had seen the care plans. All relatives told us that they felt involved in their relative’s care, which was important to them and what we would expect.

Several relatives told us about their relatives receiving regular checks of their physical health, as well as their mental health and how pleased they were that these checks were being done. All relatives told us that the communication was good and that they attended regular meetings, where they continued to receive updates about their relatives’ care and treatment and that these meetings provided them with an opportunity to ask any specific questions. One relative described the care on the ward as being “that good I do not want my relative to leave”. Another relative told us that the staff were able to manage the risks and attend to stress/distress behaviours.

Where we received feedback that was not as positive, this was about the lack of activity provision. One relative told us there was a “lack of stimulation in the ward”. Relatives told us that there were resources in the ward, such as a playlist for life, reminiscence interactive therapy activities (RITA) technology however, these were not being used. Some relatives shared a concern that people “were being left in their rooms with little stimulation”.

The feedback we received from people in Muirview Ward was mostly positive. Individuals described staff as “good”, “nice”, and caring”. We spoke with the SCN around one individual’s negative feedback where they felt that had been given a “row” by a staff member.

Some individuals told us that staff were always busy and rushing around, leaving them feeling that they did not want to bother staff. While some individuals told us that they felt safe in the ward, we heard from others who told us that did not feel safe at times. Several people told us that they were unhappy about people with a

diagnosis of dementia wandering into their rooms. These people told us that they tended to lock their door from the inside and isolate more in their room, in order to get privacy.

While some people told us that they felt involved in their care and treatment, others told us that they did not and did not want to be in hospital. We reviewed the care and treatment for the people who told us that they did not want to be in hospital to ensure that the appropriate legal authority in place.

Some people told us that they saw the doctor regularly and were able to discuss their treatment. Some were able to tell us about their rights, although for others, it was less so.

A few individuals told us that the environment was too hot and that they were unable to use the garden space as it was locked, and that there had been no access to the garden for several months due to issues with works that had been completed. For individuals who were not getting any time off the ward, they told us that they struggled with not getting fresh air, as the ward was often hot; we too found this to be the case on the day of the visit in Muirview Ward. The clinical services manager informed us that they were currently taking regular temperature checks in the ward due to the extreme heat.

The feedback from relatives in Muirview Ward was mixed. One relative told us that the staff were “nice and caring”, while another told us about the concerns they had due to the mix of individuals with a functional and organic illness in the ward.

One relative told us that they had been fully involved in the discharge planning, however, they felt that the discharge was rushed. Most relatives told us that there was lack of activities, and nothing much to do.

Two relatives told us that the communication on admission was good, but that there had been an inconsistent approach with regards to their relative’s care planning. One relative told us that they were unhappy about their relative’s care and treatment and we had further discussions with the SCN regarding this. Where relatives shared any concerns with us about aspects of care and treatment, we conveyed this to the SCN and senior managers at our feedback session and requested that these issues were followed up with relatives.

Staff in Muirview Ward told us about the difficulties and challenges of having a mix of people in the ward with both functional and organic mental illness diagnoses. We are aware that there will be times when someone with a dementia diagnosis is admitted to a ward for people with a functional mental illness. This is appropriate when a person with dementia requires assessment and treatment for a concurrent functional mental illness, or are early in the process of diagnosis, when it is unclear if the person has a functional illness or dementia.

In general, we do not think that mixed wards meet the needs of either group. Since our themed visit report was published in 2019, many health boards have taken measures to separate this service provision which has led to better outcomes for people.

Throughout the visit we saw caring and supportive interactions between staff and individuals across both wards. Elmview Ward had a sense of calm and we gained a sense that the staff knew the individuals well however, we found that the environment lacked stimulation for the individuals. We found many individuals sleeping in chairs and sofas for lengthy periods, with one person noted to not change seating position throughout the duration of our visit.

Muirview Ward appeared busier and noisier at periods throughout the day. We saw people who were disorientated around the ward and wandering into other people's rooms. We found that some people with dementia were confronting other people who did not have dementia and staff having to intervene. We found that most people who had a functional illness tended to remain in their rooms, with some choosing to eat in their rooms too.

We were told that there were no staffing vacancies across both wards, which was positive to hear. Managers told us that due to the closure of Cairnie Ward, some staff were transferred to these wards which enhanced the staffing levels and filled vacancies.

We were told that there had been several changes in the SCN position over the past 14 months in Muirview Ward, with the current SCN is due to retire soon. Managers told us that this post would be going to advert.

Care, treatment, support, and participation

Some of the people in Elmview Ward had been transferred from Muirview Ward following their assessment. We found the initial assessments in Muirview Ward to be very detailed and thorough, with a recorded plan of action with regards to the purpose of admission and what the admission hoped to achieve.

In Muirview Ward we found that the care plans were mostly detailed, covering a wide range of needs, however, some of the plans were variable in terms of personalisation.

There was evidence of care plans being reviewed regularly, but the level of detail in the reviews was also variable. We saw that some relatives and individuals had signed their care plans however, we saw others where there had been no evidence of family involvement or any recorded reasons as to why the individual had not signed their plan.

Recommendation 1:
Managers should ensure that all nursing care plans across the service are individualised, person-centred, and detail interventions which support individuals' movement towards their care goals. These should evidence individual and carer involvement, be regularly reviewed and the quality of the care plans should be audited.

In Elmview Ward we found that the care plans in place covered a wide range of needs, some more personalised than others with regular reviews taking place. We found that the stress/distress care plans lacked in detail, as the plans mainly recorded 'identify triggers, link to triggers', but there was no specific detail as to what the triggers were. Upon the review of these plans, it was difficult to know if the intervention was working to manage the person's level of stress/distress behaviours as the detail was lacking.

We would like to have seen a clear focus on the use of non-pharmacological strategies to reduce symptoms of stress and distress behaviours and staff following the care plan and applying these interventions, before considering the use of medication. However, we did not find this.

Similar to Muirview Ward, we saw that some relatives and individuals had signed their care plans however we saw others where there had been no evidence of family involvement or any recorded reasons as to why the individual had not signed their plan.

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.

Everyone across both wards had a risk assessment in place that was mostly detailed, but the risk management plans were variable in the level of detail. We also found that some of the reviews lacked detail. It was therefore unclear to see if the risk was being managed or if the interventions put in place to manage the risks was effective. We provided an example of one case from each ward, where in particular we felt that those individuals would have benefitted from psychology input to support staff in managing behaviours more effectively and consistently.

Recommendations 2:
Managers should ensure that all risk management plans provide a detailed account as to how each risk will be managed along with evidence of ongoing review of the risks.

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

We found completed ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) certificates that appeared to be in order, apart from one in Muirview Ward which we brought to the attention of the clinical lead, as the certificate was incomplete.

Care records
Information about individuals’ care and treatment was held in the electronic system ‘Morse’. We found it easy to access daily recordings, minutes of meetings, and attachments. However, for documents such as care planning and risks assessments, this was more difficult.

We were told that there were specific sections where the staff member would develop and store these documents and therefore we spent a lot of time searching for these. We also heard similar concerns from staff, who told us that it was not always easy to find certain documents, as this could depend on who put the document on the system.

Recommendation 3:
Managers must ensure that there is a clear process to guide the storage of documents on the electronic recording system.

Muirview Ward had developed a prompt card to support staff with their daily recordings following on from our recommendation last year. We had been provided with a report from the SCN about the continued progress since this initiative was put in place to meet the recommendation. However, we were disappointed that we did not find this on the day of the visit. We found that the majority of the daily recordings lacked detail, with many recordings that simply said, ‘accepted supper’, ‘evident in bed space’ and ‘accepted medication’.

In Elmview Ward we found that the daily recordings varied in quality. We saw some detailed accounts of the individual’s presentation documented however, we found other recordings that lacked detail.

We found nursing entries in three sets of care records across both wards, where pejorative language was used without any context. These words described individuals as being ‘brittle’, ‘demanding’, ‘confrontational’ and ‘argumentative’. We provided examples of these individual records to the senior managers at our feedback session.

In Muirview Ward, we found where one-to-one discussions between individuals and staff were being offered, there was a fuller, detailed account of the individual’s presentation, and staff’s recording as to how the person benefitted from the sessions, along with the individual’s views about their admission and their care and treatment. We would also have liked to have seen more discussions about individuals’ rights in these one-to-one sessions. We saw good examples of nursing

staff discussing the care plan goals with the individual and gaining the persons views.

Multidisciplinary team (MDT)
We were told that there were three consultant psychiatrists who covered Muirview Ward and one of those psychiatrists also covered Elmview Ward. We were told that the MDT meeting took place weekly in Muirview Ward and everyone's care was reviewed at least fortnightly in Elmview Ward, or earlier if necessary.

The professionals who attended these meetings mainly consisted of nursing staff, psychiatry and pharmacy. The MDT meeting records for both wards were stored in Morse, and we found that the records were detailed, providing a good account of the persons ongoing mental health, their physical health care, with nursing staff providing an update about the person's presentation since the last meeting.

Where families were involved, we found that their views were clearly recorded and where the individual wished to contribute, this was evident too. There were sufficient prompts on the electronic system to ensure treatment forms were in place, that time out of the ward was reviewed, along with clear recording of the persons legal status. We found that all meeting records had a clear plan of action, with some more being more detailed than others.

We were told Elmview Ward also had a separate high risk falls meeting on a fortnightly basis to discuss individuals who had either had falls or who were felt to be at significant risk of falling, and for those who were actively mobilising, but were unsteady or otherwise at risk. This meeting consisted of the physiotherapist, psychiatrist, pharmacist and dietitian.

In terms of physical health care monitoring we were told that this was carried out by the consultant psychiatrist or the junior doctor, as there was currently a gap across the service due to the physician leaving before Christmas. We were told that the service was seeking a locum doctor to fill this gap. We found that there was detailed and ongoing monitoring of people's physical healthcare from the point of admission across both wards, which was what would be expected. We saw individuals being supported to continue to access opticians and dentists while in hospital.

The wards did not have a dedicated occupational therapist however, cover was provided by the OT service based at Stratheden Hospital. We were told that referrals were actioned quickly and that most referrals were for functional assessments to support discharge planning.

We wanted to find out about the psychology provision across both wards. We spoke to the older adult psychologist who told us that there was one psychologist who covered all four older adult inpatient wards across Fife.

Part of the psychologist's role was to receive and screen referrals from the wards, carry out formulation work, meet with families, attend clinical meetings and deliver training to staff around stress/distress. The psychology service was also delivering a dementia carers education programme. Psychology can have an important role in the treatment of functional mental illness in older people, both directly, with the individual, and by supporting nursing staff to deliver therapy. We would expect that all assessment wards have timely access to psychology input.

While we appreciate that there was a level of input from psychology to the other adult wards, it would appear that the service would benefit from additional resource as we found people on this visit that we felt would have benefitted from psychology input. We will request an update from the psychology lead with regards to the provision across older adult inpatient wards.

The music therapist provided an afternoon session one day per week to people in Elmview Ward and we were told that there had been discussions about individuals from Muirview Ward being able to join this session. We were told that individuals had benefitted from this resource and heard of examples where this had been effective in managing peoples stress/distress behaviours.

With regards to people who were in hospital awaiting discharge, we were told that the clinical services manager met fortnightly with the discharge co-ordinator to discuss peoples discharge pathways and identify any potential challenges early in the persons admission to enable progress to be made.

We were told that there were five people whose discharge was delayed in Elmview Ward and three people in Muirview Ward. We heard that some of the delays were due to legal orders, care placements being available and care packages.

Use of mental health and incapacity legislation

On the day of the visit, six people in Muirview Ward and nine people in Elmview Ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to detention status was easy to locate on the electronic system.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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 across both wards.

We wanted to find out if any individuals who had been admitted to the wards on an informal basis had been prescribed and administered 'if required' intramuscular (IM) psychotropic medication, as we had raised concerns about this practice from

another recent visit in Fife. Administration of 'if required' intramuscular (IM) psychotropic medication almost always requires the legislative authority of the Mental Health Act. The Commission is concerned when IM 'if required' medication is being prescribed for people who are receiving care and treatment informally. This is because it is unlikely that there would be consent in place to receive this treatment if it had to be administered in circumstances where restraint may be required. We consider it best practice for a medical review to be arranged if there are exceptional circumstances where IM medication may be required.

We found that there were some individuals in Muirview Ward who had been prescribed 'if required' IM medication, and who were not detained under the Mental Health Act however, this medication had not been administered. We raised our concern about this on the day of our visit and these medications were discontinued.

For those people that were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) we found it difficult to locate all paperwork in relation to power of attorney (POA) certificates in Muirview Ward. There were three individuals where the POA document was not on the electronic system, and we saw some on the electronic system where it was only the front sheet of the POA document. Following discussion with the SCN, it was positive to hear that they had already made attempts to rectify this following individuals' admission.

In Elmview Ward we could not locate one POA order on file. We found recorded entries where the documentation had been requested and managers agreed to follow this up.

Recommendation 4:
Managers must ensure that all POA documents and covert pathways are kept together with all other treatment certificates and prescription Kardex.

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 and record this on the form.

We found that all section 47 certificates in place had been completed in accordance with code of practice for medical practitioners, and all had an individualised treatment plan in place. Apart from one in Elmview Ward, there was no evidence that welfare proxies had been consulted. In Muirview Ward we also found one certificate which had been completed before the appointment of the welfare guardian and we advised the consultant psychiatrist to review the certificate and ensure consultation with the appointed welfare guardian had taken place.

We also asked the psychiatrist to review one individual's capacity in Muirview Ward as there was no certificate in place and indication in the care records that the person was assessed as lacking capacity.

For individuals who had covert medication in place, all documentation was in order in Muirview Ward. In Elmview Ward, we found two individuals where the medications were not listed on the documentation, therefore we requested this to be addressed. We could not locate the covert pathways for four individuals in Elmview Ward, as these were not kept in paper file with the other certificates. We informed managers that all certificates/pathways should be printed off and kept together with the prescription Kardex's.

The Commission has produced good practice guidance on the use of covert medication.[2]

Rights and restrictions

The doors to both wards were locked, with a locked door notice displayed on entry to the wards and a policy in place. For people who were detained under the Mental Health Act, this provided the authority for the person to remain in hospital, however, for people who were informal, we felt that some individual records lacked discussion about this, therefore it was at times unclear if the person was satisfied and willing to remain on the ward. We would suggest that individual rights need to be better evidenced in care records and in the care planning process.

The ward had good support from advocacy services, and we were pleased to know that this service was available for everyone and not just for people who were detained under the Mental Health Act.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. No one across either ward was subject to specified person measures.

The Commission has produced good practice guidance on specified persons[3].

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 did not find any advance statements across the wards. Most of the individuals in Elmview would be unable to

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492
[3] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

make an advance statement due to their advanced dementia and this was the same for individuals in Muirview Ward. For individuals who had a functional mental illness we suggested to staff that these should be discussed throughout the persons recovery journey.

The Commission has developed *Rights in Mind.*[4] 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

We would expect to see a person-centred activity programme that is based on a multidisciplinary assessment of an individual's needs and strengths. Such a programme should include options both on and off the ward, where appropriate for therapeutic and recreational activity and reflect the social, cultural and religious preferences of each individual.

Activity has the potential to restore, maintain and improve physical and mental health. Staff with relevant knowledge, skills and confidence providing a range of activities can enrich the quality of life for an individual, build up confidence and enhance relationships within the ward. There should be adequate space and opportunity to engage in recreational and therapeutic activity in and out with normal working hours.

In our visit report from both these wards in 2022, 2023 and 2024, we noted concerns about the wards not having a daily programme of therapeutic activity provision. The activity co-ordinator that was in place at that time, was shared between three older adult wards. During this visit, both wards still had no appointed activity co-ordinator in place.

In Muirview Ward we were told that an appointed staff member was allocated for the morning, afternoon and night to carry out activities. In the action plan that we had received from our visit in 2024, the weekly programme of activities was due to start in August 2025. Given our visit was last year, we were concerned to find that it took the service this long to put in place an activity programme. Some individuals in Muirview Ward told us about input from music therapy and horticulture service. Although we heard about some snippets of activity, this was not on the level we would expect.

We were told that Muirview Ward had recently started a coffee and blether time on a Saturday morning for carers to attend. This had just started so we were unable to get any feedback. There was an activity board displayed in this ward however, on the day of the visit, some of these activities did not take place.

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

When we visited Elmview Ward we found several individuals sleeping in chairs throughout the day, and on observation, two individuals who had not moved out of the same chair for the whole day on the visit.

A volunteer visited Elmview Ward one morning per week and provided activities, which we saw on the morning of our visit.

The music therapist provided one afternoon session per week in Elmview Ward and we are aware that the SCN in Muirview Ward was considering referring individuals to this group, but this would be dependent on staff being able to leave the ward to support them to do this. In Elmview Ward there were ample resources in the activity room, such as playlist for life, RITA, a piano however, these were rarely used.

We spoke to staff about activities and did get a sense that they recognised the importance of activities in supporting people with their stress/distress behaviours and as part of their recovery. However, we continued to be significantly concerned at the low level of therapeutic activity provision across both wards, especially as we had been raising concern around activity provision since our visit in 2022. Daily activities continued to be dependent on the availability of nursing staff, and we continued to hear that it was difficult to prioritise activities when there were pressing clinical needs of individuals who required enhanced levels of observation or high physical health care needs. We also heard from nursing staff that when the ward was fully staffed, staff would at times be moved to other wards, resulting in them being unable to provide the activities they intended to offer.

Although both wards had activity care plans in place, there was lack of recording of activities being offered, which is what we heard from individuals and relatives. Therapeutic activity provision can support a person with their stress and distress behaviours however; there was lack of evidence of these methods being used as part of the persons care and treatment.

Senior managers told us that the vacancy management form for the activity co-ordinator post had been completed in September 2023. However, due to a change of leadership a further one had been submitted which still had to go through an approval process. We were told that there had been initial approval and they were now waiting from approval from the Fife wide management team. We continue to have concerns about this lack of progress over the past few years and will escalate this to the chief officer of the Health and Social Care Partnership (HSCP) and request an update. As this recommendation has not been met, we will repeat it again.

Recommendation 5:
Managers must appoint an activity co-ordinator to ensure there is sufficient therapeutic activity provision to individuals in Elmview and Muirview Wards over a seven-day period.

The physical environment

As part of the redesign of older adult mental health facilities, both of these wards opened in 2009. Individuals had their own en-suite bedrooms with integrated wardrobes. Managers told us that there had been ongoing ligature reduction works in some of the bedrooms. We heard from staff and some individuals that the sliding doors to en-suites were not always easy to use. All bedrooms had an outward facing window to the grounds of the hospital and we heard from people that they enjoyed the views from their windows, as well as the window seats in the bedrooms.

Both wards had communal dining areas, smaller quieter sitting areas, and communal lounge areas, which led out to the enclosed gardens. The garden area in Elmview Ward was well presented and had ample space for people to walk around, which we saw them doing on the day of the visit. We heard from families that they also enjoyed using this space.

Muirview Ward had secured monies through the Fife health charity to replace the outdoor slabs in the garden. Unfortunately, after completion of the works the material began to lift from the outdoor space and access had to be stopped due to the risk towards individuals. Managers told us that the estates department were addressing this with the contractors. We heard from individuals that they had not been able to use the garden area all summer however, staff told us that they managed where appropriate to take people out to the sitting areas in the hospital grounds and to the benches located just outside the ward.

We will seek an update from senior managers about the progress of the garden works.

Both wards were spacious and bright with ample room to wander for people with dementia. In Elmview Ward there was a separate activity room that had resources and a sensory room. We found that the ward had good signage in place and there were other toilet and bathroom facilities around the ward.

We saw across both wards that people had their name displayed on their doors, however, this was often in different fonts which would have been difficult for some to read and recognise. We suggested to seek advice from the OT around individual signifiers for people with dementia to aid them to recognise their room.

Where wards are mixed (admit people with dementia alongside those with a functional mental illness), the physical environment should provide privacy and dignity for both groups and staff should be suitably trained and resourced to meet the complex and diverse needs of those on the ward.

In Muirview Ward we found that due to the mix of people with dementia and organic illness, that people were not always able to maintain their skills while in the ward, as

the small kitchen was kept locked due to the risk associated with the people with dementia. With this facility being locked, individuals were unable to make tea or coffee when they wished to do so, which was disappointing.

There were no separate facilities for people with a functional illness and what we heard from people was that they preferred to stay in their room as they did not want to join in or sit in a communal area, where the environment could at times be noisy. Although this offered people privacy, it could lead to isolation and negatively impact on people's recovery.

Summary of recommendations

Recommendations1:
Managers should ensure that all nursing care plans across the service are individualised, person-centred, and detail interventions which support individuals' movement towards their care goals. These should evidence individual and carer involvement, be regularly reviewed and the quality of the care plans should be audited.

Recommendations 2:
Managers should ensure that all risk management plans provide a detailed account as to how each risk will be managed along with evidence of ongoing review of the risks.

Recommendation 3:
Managers must ensure that there is a clear process to guide the storage of documents on the electronic recording system.

Recommendation 4:
Managers must ensure that all POA documents and covert pathways are kept together with all other treatment certificates and prescription Kardex.

Recommendation 5:
Managers must appoint an activity co-ordinator to ensure there is sufficient therapeutic activity provision to individuals in Elmview and Muirview Wards over a seven-day period.

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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