Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 2, Queen Margaret Hospital, Dunfermline, KY12 0SU.

Date of visit: 17 February 2020

Where we visited

Ward 2 is an adult acute admission psychiatric ward. It is based in a general hospital in Dunfermline and is a 29-bedded facility. It is a mixed ward and has two male dormitory areas, two female dormitory areas, and six side rooms. It covers the catchment area of West Fife and is supported by five consultant psychiatrists. On the day of the visit there were 28 patients on the ward. We were advised that there were no patients placed out with NHS Fife; however, one patient had been admitted to Ward 2 from another NHS Board.

We last visited this service on 6 March 2019 and made recommendations in relation to care plans being audited regularly and that they reflect the ongoing care and treatment being provided. We also recommended that action should be taken to address the shower facilities and that any maintenance requests were dealt with efficiently. We received an action plan in response to these recommendations within three months of our visit.

On the day of this visit we wanted to follow up on the previous recommendations and meet with patients. We were also keen to look at the levels of activity and meaningful occupation for patients.

Who we met with

We met with and/or reviewed the care and treatment of eight patients. This was an unannounced visit and there was limited opportunity to meet with carers, relatives or friends on the day. We did, however, manage to speak with one carer.

We spoke with the senior charge nurse (SCN), two staff nurses, and other members of the nursing team on the day. We were told that the ward team have had a challenging year with a number of changes in staffing due to a series of retirements. There is a relatively new SCN in post and developments are in place to look at revising ward structures and overall philosophy.

Staff told us that the ward is busy with a high turnover of patients. Since our last visit, staff also advised that the ward has noted an increase in illicit drug use and, at times, some visitors bringing substances onto the ward. The ward has adopted a zero tolerance approach to this along with support from Police Scotland, and feel that this has helped to manage the issue.

We were also advised that the ward is about to experience some disruption as environmental work is about to take place within the main dining room. In order to ensure a communal space is maintained, one dormitory will be closed and redesigned to become a sitting room. This will lead to a temporary reduction of six beds for a period of time. It is estimated that this work will take between four to six weeks and it is hoped that it will present minimal disruption.

We were advised that there is no agreed admission criteria for the ward but understand that a draft document is being developed within NHS Fife. We would be interested to hear how this work develops and impacts on ward admissions in the future.

Commission visitors

Paula John, Social Work Officer
Philip Grieve, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The patients that we spoke to were generally happy about their care and treatment. They described this as good, and indicated that the majority of the nursing team were supportive and approachable. However, several patients did make reference to having more difficult relationships with a small cohort of the care team. These comments were independent of each other and, although no staff were identified in these discussions, a consistent theme of poor engagement did emerge. We passed these comments onto the SCN on the day of the visit, with the aim of possibly exploring this further with both patients and staff.

Patients explained that they can spend time with nurses on a one-to-one basis and highlighted that this tends to be initiated by them rather than being offered by nursing staff. They added that the staff appear to be busy and do not always have enough time. We were told that the practice of one-to-one nursing interventions is happening within the ward; however, the recording of this could be improved. We did witness kind and caring interactions between staff and patients.

Contact with medical staff appears to be happening on a weekly basis for all patients. There are five consultant psychiatrists, each holding a weekly ward meeting. Despite this, staff advised that this situation is manageable. Patients appeared generally happy with the medical input into their care and treatment and had participation in ward meetings. We were pleased to see that there is a consistent medical component contributing to the care and treatment of patients within the ward. There was evidence of a multidisciplinary approach within the weekly meeting with representatives from nursing, occupational therapy and social work. Psychology is not available on a regular basis. However, if it is indicated, the care team can refer to the community mental health team who can provide psychology within the ward setting if required.

A peer support worker is employed on the ward, and staff commented that this continues to be an important role in promoting engagement, and discussing care and treatment.

We looked at care plans, risk assessments, and other standardised documents within the care record. We were pleased to see a consistent approach to the completion of these documents. There has been an improvement in person-centred care planning, and interventions were personalised and goal-orientated. There was also evidence that they were being reviewed with some analysis. However, there was still little evidence that patients were involved in the care planning process. Most of the patients we spoke to stated they didn't know about their care plans or had been involved in their completion. The 'Working with Risk' document as adopted by all wards across NHS Fife, was found to be completed fully with significant detail. It identified interventions to minimise risks and was reviewed, updated and evaluated regularly. We were advised that this document is also under review and maybe adapted in the future.

We were informed that the nurses audit their own care plans on a weekly basis; however there is no standardised audit tool and there was no record of this audit.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Recommendation 1:

Managers should review and regularly audit the care plans to ensure that they reflect the ongoing care and treatment being provided.

Use of mental health and incapacity legislation

For patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('The Mental Health Act'), we were able to locate the appropriate Mental Health Act paperwork which is contained within the paper case file on the ward. We were pleased to see that there was no issues with the paperwork relating to the giving of medication, and for the prescription sheets reviewed; all were up-to-date, signed. and appropriately authorised.

There were no patients who had been assessed as being unable to make decisions in relation to medical treatment.

Rights and restrictions

We were advised that the door to Ward 2 is locked at all times for reasons of safety and security. Access can be obtained by a door entry system and those wishing to leave require to ask a member of staff. There is a locked door policy and patients can come and go freely, unless particular restrictions are in place.

However, most of the patients we spoke to on the day were not aware of their rights either as an informal patient or a patient detained under the Mental Health Act. It was clear that patients had a limited understanding of their rights. We were advised that patients are informed of their rights on admission. There was no evidence within the care record that this had taken place. Patients detained under the Mental Health Act were aware of how to access advocacy services and there were regular visits to the ward by this service.

We noted that there was one patient subject to specified persons regulations under the Mental Health Act. These give ward staff the authority to restrict specific items such as phones, or limit correspondence. A rationale for this must be clearly documented and details of review within the notes. We were pleased to find these, and the patient concerned was aware of this status.

Recommendation 2:

Managers should ensure that all patients who are detained under the Mental Health Act and those who are informal are aware of their rights when they are in hospital.

Recommendation 3:

Managers should ensure that there are regular reviews of the locked door to include consideration of less restrictive interventions to ensure patient safety.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in the mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

Activity provision within the ward remains a challenge. There was no evidence of an activity planner for patients in any of the public areas. Patients reported being bored on the ward with limited activities to participate in. On our last visit patients spoke of involvement in arts and crafts groups, music groups and relaxation and exercise delivered by nursing and OT staff. On the day of the visit, nursing staff advised that some of these groups did continue to take place, but at times it was dependent on staff numbers.

OT services are attached to the ward, and are beginning to develop input, but this resource is also limited.

We also heard of future plans to improve this situation and employ a full time activity co-ordinator. This is with the aim of supporting recovery focused care and look forward to this being progressed. One patient that we spoke to said that she missed the relaxation groups. There was little recorded in patient records relating to therapeutic activities, either of activities taking place and being offered.

We heard that the staff are actively involved in the implementation of "From Observation to Intervention" and "Improving Observation Practice "developed by the Scottish Patient Safety programme. This work aims to develop observation practice by looking at more therapeutic activity for acutely unwell patients. It is hoped that this will contribute to an overall improvement in activity provision within the ward. As part of this work, we noted the use of the non-pharmaclogical intervention stickers throughout the case notes which highlight alternative interventions to medication.

Recommendation 4:

Managers should ensure that activity provision is reviewed and participation is recorded and evaluated.

The physical environment

As mentioned in our previous reports, the physical environment is in need of refurbishment. There has been some improvement with the addition of murals and notice boards however, the overall environment remains dated in appearance. We were pleased to see that the shower room flooring had been addressed as indicated within the last report. Significant work is about to take place in order to maintain and improve patient safety. This will cause some disruption

within the clinical area and further reduce space. Staff advised there is already a lack of meeting and quiet space within the ward environment.

Recommendation 5:

Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as practicable and should ensure a programme of work, with identified timescales, to address the environmental issues is in place.

Summary of recommendations

1. Managers should review and regularly audit the care plans to ensure that they reflect the ongoing care and treatment being provided.

2. Managers should ensure that all patients who are detained under the Mental Health Act and those who are informal are aware of their rights when they are in hospital.

3. Managers should ensure that there are regular reviews of the locked door to include consideration of less restrictive interventions to ensure patient safety.

4. Managers should ensure that activity provision is reviewed and participation is recorded and evaluated.

5. Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as practicable and should ensure a programme of work, with identified timescales, to address the environmental issues is in place.

Other comments

Nursing staff told us about the recent reduced number of use of increased levels of observations within the ward. They continue to work through the 'Safe Wards' model and this is evident with the provision of a welcome board and staff information displayed for patients and visitors. The non-pharmacological intervention stickers within the care record are linked to the national work relating to "From Observation to Intervention" and "Improving Observation Practice". We noted within the main office the efforts to engage the nursing team and what the team can do to improve working relations and morale.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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 MWC 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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