Mental Welfare Commission for Scotland

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

Date of visit: 30 November 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Ward 2 is an adult acute mental health admission ward based in a general hospital in Dunfermline, Fife. Prior to the Covid-19 pandemic this ward's bed capacity was 29 beds, however since 2020 the number of beds has decreased to 22. We were told the nursing establishment has remained unchanged following the reduction in bed numbers. We last visited this service on 17 February 2020 and made recommendations in relation to care planning and the requirement for regular auditing; rights and restrictions in relation to the ward's locked door while taking into account patients subject to Mental Health Act legislation being made aware of their rights. We also made recommendations about how activity provision available in Ward 2 was recorded and evaluated. Lastly, we included a recommendation about the environment. While there had been some notable improvements we identified areas that required attention, we also recommended a programme of works with timescales for repairs and improvements be undertaken as soon as practicable.

Who we met with

We met with and/or reviewed the care and treatment of 11 patients. There were no carers or relatives available to meet or speak with us for this visit.

Prior to visiting the ward we had contact with senior nursing staff. On the day of the visit we met with members of the clinical team including nursing staff, service managers and a consultant psychiatrist.

Commission visitors

Anne Buchanan, Nursing Officer

Claire Lamza, Senior Manager

Graham Morgan, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

The patients we spoke with were largely positive about the support, care and treatment they received from the clinical team in Ward 2. However, during our meetings with patients they was a consistent theme of concerns about nursing staff shortages and how patients felt this impacted on the input they received. We heard from patients that they found nursing staff to be approachable although due to staff shortages, one-to-one therapeutic work was not as available as often as they would have liked. Patients valued time spent with the nursing team and their keyworkers although were frustrated that activities were often postponed or cancelled due to lack of nursing staff. Therapeutic engagement was discussed and while patients appreciate the clinical team are making efforts to promote a recovery model of care, some patients told us they feel their progress is being hindered.

There is a multi-disciplinary team (MDT) attached to Ward 2. In the core team there are mental health nurses, healthcare support workers including a mental health peer support worker, psychiatrists, an occupational therapist (OT) with additional input from pharmacy, psychology and physiotherapy.

We were keen to understand the model of care delivered in Ward 2 because we are aware there are six consultant psychiatrists attached to the ward who may adopt different approaches to care and treatment for their own patients. We heard that in order to ensure nursing staff are not having to consider multiple models of care and treatment, there are monthly meetings with senior medical staff to discuss the philosophy of care for Ward 2. This is to ensure there is a sense of consistency to allow staff to work with their patients while encouraging robust communication within the MDT.

From July 2021 patients' notes have largely moved from paper files to an electronic record system. This transition from paper to electronic record keeping is in its infancy with the clinical team working with IT staff to address difficulties in the new system. We were told the transition has been challenging with risk assessments and care plans causing the greatest concern. Documenting and updating risk assessments is not possible on the new system therefore leaving nursing staff to have to regularly re-write the assessment or it not being updated as regularly as required.. This poses a significant risk to patients if the assessments are not updated in a timely fashion. We discussed this concern with senior nursing staff on the day of our visit. We were told there are regular meetings to highlight any issues with the IT team responsible for implementing the new electronic record system.

Following our last visit to Ward 2, we made a recommendation in relation to care planning and the need for regular audits to improve quality and ensure care and treatment is person-centred. We heard about the work related to the adult mental health person-centred implementation guide for nursing staff. This document sets out the principles associated with a 'Specific, Measurable, Achievable, Realistic, and Timely' (SMART) model of care planning. While we were able to see a clear improvement around the structure, implementation and reviews recorded in each patient's file, we saw limited evidence of patient participation and this was acknowledged by some of the patients who we spoke to. While some patients felt

they contributed to their own care plans, there were patients who were unable to inform us of any detail in their care plans. We also noted that specific goals, who was going to support the patients to achieve those goals and interventions required needed further detail.

On the day of our visit, we were advised that a new care plan template is in development, and this will ensure keyworkers will design care plans that are person-centred and inclusive.

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

Recommendation 1:

Managers should ensure care plans provide evidence of participation from the patient, including the planning and patient's view of their goals to aid recovery.

We were informed by patients and the clinical team based in Ward 2 that there has been a significant delay in relation to patients who are prescribed electro-convulsive therapy (ECT). Patients told us that this has impacted on their recovery as they are having to remain in hospital longer than they had felt was necessary. We discussed this issue with the clinical team and were told that a plan has been agreed to improve capacity and reduce waiting times. We will seek an update from managers to ensure current concerns in relation to the provision for ECT are overseen effectively.

There is a MDT meeting each day, with specific medical staff discussing their own patients on a weekly basis. In electronic records there is evidence of the minutes from meetings, reviews and actions for specific members of the MDT. We were advised that currently there are no patients awaiting accommodation or a package of care that could delay their discharge from hospital. Liaison with the community mental health team is promoted through the discharge from hospital nurse. This is a recent appointment and one that has proved to be invaluable; this resource was described as a bridge between inpatient care to community services, thus promoting sustainable discharges from hospital to home.

We met with the ward's mental health peer support worker. This role was highly valued by patients and the clinical team. The peer support worker has a unique position in the team, bringing their own lived experience to support patients in the ward and advise staff in the team. We were pleased to see that peer support has become imbedded in patient care; it provides optimism and a sense that recovery is achievable and is accessible for all patients in Ward 2.

Use of mental health and incapacity legislation

On the day of our visit patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Of those patients subject to compulsory treatment, we reviewed the legal documentation available in their files. Paperwork relating to treatment under part 16 (s235 -248) of the Mental Health Act was in good order. The

authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were available.

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 these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions to be regularly reviewed. It also provides the appropriate framework for the review of the restrictions and informs the patient of their right to appeal against these. We found that where patients had been made 'specified persons' under the Mental Health Act, authorising certain restrictions, the necessary certificates and reasoned opinions could be identified in the patient's records. We are aware that the move from paper to electronic records has meant certificates that would usually be located in a paper file, are now uploaded onto an electronic record as well as being located in a prescription kardex.

Our specified persons good practice guidance is available on our website: https://www.mwcscot.org.uk/node/512

Rights and restrictions

We were informed that the door to Ward 2 is locked at all times for reasons of safety and security. Access can be obtained by the door entry system and those wishing to leave require to ask a member of staff. There is a locked door policy in place advising all patients about the rationale for the door remained locked, and to ensure that those who do not have specific restrictions in place are aware of their rights to leave the ward when they chose to. We were made aware there have been ongoing issues with ward's door entry system, with patients leaving the ward without staff knowledge or agreement. We were told this has been highlighted as a concern in relation to patient safety. Costings for a new entry system have been completed that include an air lock door mechanism.

We were advised that patients have access to independent advocacy and legal representation. During the Covid-19 pandemic meetings between patients and their legal representatives or advocacy support workers had been mainly undertaken by telephone. More recently, legal representatives have met with patient's in-person, on the ward. Advocacy support workers continue to use virtual contact options to meet with patients in the ward; we were told by patients and staff that a return to face to face meetings would be helpful, particularly prior to Mental Health Tribunal for Scotland hearings.

Recommendation 2:

Managers should review with independent advocacy service when in-person meetings with patients are able to recommence.

Ward staff, including social workers with mental health officer status (MHO) provide information about how to access legal representation. Leaflets and contact information is made available with private access to telephones in order for patients to seek representation during their admission to hospital.

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

Activity and occupation

We were informed there is an activity timetable and patients are encouraged to engage with the activities that are currently available. However, we were told by the patients we spoke to that activities scheduled are frequently cancelled due to staff shortages. This a source of frustration for patients as they value time spent with each other either in small groups or one-to-one therapeutic engagement with staff. We were told there is an OT attached to Ward 2, with the main focus on functional assessments with care plans specifically to address issues that may be a barrier to discharge from hospital to home.

Patients told us that while they appreciate there are staff shortages and activities may be limited, they would welcome more opportunities to have time off the ward for walks outdoors and fresh air. Equally, having games equipment they could use either with each other or by themselves would also be welcomed. Patients we spoke to found they were often left feeling bored; with little to occupy their day and would have benefited from therapeutic engagement with members of the MDT.

Recommendation 3:

Managers should review the current activity timetable to ensure activities promoted are available when scheduled.

The physical environment

As mentioned in our previous reports, the physical environment is in need of refurbishment. There has been some improvement specifically in the sitting room and dining area. However, the overall environment remains dated in appearance. There are currently four dormitories, equally split between male and female patients. There are six single bedrooms with en-suite facilities. Bathrooms that we saw were also dated, with shower room doors that did not fit properly and problems with their fixings, compromising privacy. Flooring was stained and worn in places. While some patients were happy to sleep in dormitory type accommodation there were a number of patients who found the experience of sleeping in dormitories distressing. They highlighted their need for safety, privacy and advised us that they often found they were unable to sleep due to other patients remaining active overnight.

Patients have access to a court yard area attached to the ward. While attempts have been made to soften this environment it remains stark and uninviting. We were told this area until recently had been used by patients to smoke however since the implementation of smoke free hospitals in Fife, it is not been used. Patients we spoke to were keen to be able to sit outside when the weather allows however felt the court yard would benefit from additional investment of garden equipment and plants.

Recommendation 4:

Managers should ensure that outstanding repair and refurbishment work is undertaken and regular environment audits with specific timescales for improvement are agreed.

Recommendation 5:

Managers should ensure that the outdoor space available to Ward 2 is welcoming and attractive for patients and visitors to use.

Summary of recommendations

1. Managers should ensure care plans provide evidence of participation from the patient, including the planning and patient's view of their goals to aid recovery.

2. Managers should review with independent advocacy service when in-person meetings with patients are able to recommence.

3. Managers should review the current activity timetable to ensure activities promoted are available when scheduled.

4. Managers should ensure that outstanding repair and refurbishment work is undertaken and regular environment audits with specific timescales for improvement are agreed.

5. Managers should ensure that the outdoor space available to Ward 2 is welcoming and attractive for patients and visitors to use.

Service response to recommendations

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

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

Suzanne McGuinness
Executive Director (Social Work)

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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