Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 4, Queen Margaret Hospital, Whitefield Road, Dunfermline KY12 0SU

Date of visit: 8 September 2022

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 4 is based in Queen Margaret Hospital, in Dunfermline. It is a mixed-sex 18-bedded ward for older adults; on the day of our visit there were seventeen patients. Patients admitted to Ward 4 typically have diagnoses of dementia-related conditions. Care and treatment is provided by a multidisciplinary team (MDT) that includes medical and nursing staff, occupational therapy, speech and language therapy, physiotherapy and input from the older adults' community mental health teams. Ward 4 is considered to be a transitioning ward for older adults who will be returning home with packages of care, and is to support their discharge, or for those moving into long term placements in care homes.

We last visited Queen Margaret Hospital older adult in-patient wards on 27 January 2016. We highlighted on that occasion the need for managers to consider the environments in relation to supporting individuals with dementia. We were concerned the wards were not considered 'dementia friendly' with limited scope to work with patients who have sensory needs or behaviours that can challenge. We have been informed older adult wards have reduced their bed numbers in part due to the Covid-19 pandemic. We were told that with fewer patients, this has allowed staff to have more opportunities to engage in therapeutic engagement. We were told the ward has had some re-decoration in the main sitting room, which also acts as a shared dining room for patients. There were plans for the ward to have additional improvements to the environment however timescales have not yet been agreed.

On the day of this visit we wanted to follow up on the previous recommendations, and we were keen to hear about how the ward-based team had managed through the Covid-19 pandemic, what the challenges have been for patients who had increased restrictions placed upon them, and whether restrictions had an impact upon relatives and carers.

Who we met with

We met with seven patients and had the opportunity to review their individual care records. We also met with three relatives on the day of our visit.

We spoke with the service manager, the senior charge nurse, and the lead nurse prior to the day of our visit. We had further opportunities to meet with and listen to the views of the ward-based team on the day of our visit, including the head of nursing for Fife HSCP mental health services.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

What people told us and what we found

Care, treatment, support and participation

We met with a number of patients and their relatives and while they all spoke positively about their experiences of Ward 4, there was a view that greater emphasis should be given to the patients' personal appearance. For some relatives this was important, as what they wanted was for the member of their family to have their hair, nails and clothing to be of a standard they themselves would have wished for, and felt personal grooming should not be left for relatives to undertake. However, we did hear from relatives that they felt included in discussions about the patients' care and treatment. Nursing staff provided regular updates on progress and offered support when they could see relatives needed it.

For patients, the availability of nurses' time was important to them. "Nurses are always there for you when you need them" and "the team make me feel safe" was a common theme heard from patients we met with. There was a recognition the nursing team were exceptionally busy and at times the use of agency and bank staff was raised as an issue.

Relatives we spoke with regarded the nursing team as approachable and were impressed when nursing staff had expanded their skills in order to help their relative with their communication needs by learning British sign language (BSL). For some families visiting a relative in hospital was very new to them and told us that this could be rather daunting. We heard that having a booklet or guide to help families in the initial few weeks would be useful; this would enable communication or help them and their relative adapt to being in hospital. We were able to discuss this with the leadership team on the day of the visit.

While reviewing individual care records we were keen to pay attention to individuals' care plans. We were told patients who displayed stressed and distressed behaviours, often associated with dementia, had care plans that were adopted from the Newcastle model. This model of care supports patients by understanding the unique needs or triggers that cause distress; by adapting interventions to reduce psychological distress and that invites the care team to be consistent and person-centred. We were informed training has been provided for all staff including health care support workers. In the care plans we reviewed, we would like to have seen greater emphasis on interventions and reviews, that took into account whether the care plans that were in place were meeting the needs identified from assessments. While some care plans offered clear guidance to support patients, particularly during times of stress and distress, we would expect to see a consistent approach to care planning and evidence of regular reviews.

We were aware that in the service as a whole, care plans and reviews were being worked on and suggested using the Commission's published good practice guidance on our website to help in the process. 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 carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Multidisciplinary team (MDT)

Ward 4 had a broad range of disciplines either based there or accessible to them. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and to give an update on their views. This also included the patient and their families, should they wish to contribute. It was clear to see from these notes when the patient was moving towards discharge, as community services also attend the meetings. To support patients discharge from hospital to a care home placement, there has been an introduction of a liaison nurse to facilitate communication. The liaison nurse supports the patient, their relatives and the care home team. This outreach model has improved communication while also supporting a sustainable discharge from hospital based care to home/care home. Clear, seamless communication has enabled care staff to support patients in the transition period, and assisted in the adaption to a new environment using care plans that have already been identified as effective.

There were a range of disciplines available for patients and we were told referrals to occupational therapy or speech and language therapy were responded to without any delays. There is an activities coordinator who shares their time between Wards 1 and 4. The ward-based team recognised patients enjoy time spent with the activities coordinator, either individually or in small groups. Of the patients we spoke with, they told us they enjoyed therapeutic and recreational activities however would also like to more time with nursing staff too. They informed us that often due to clinical activity in the ward, this is not always possible. Agency and bank nurses were available however, they don't always know individual patients and some patients and relatives we spoke to found this difficult.

Care records

Information on patients care and treatment was held in the 'MORSE' electronic record system. The change from paper record keeping to electronic has been recent however, we were told staff have found the transition fairly straightforward. We found patient's records easy to navigate, there was a clear focus upon individual patient's mental and physical well-being, with a number of physical health assessments being completed.

Patients admitted to Ward 4 require assessments based upon a number of areas. A Holistic Older Adult Assessment tool (HOAAT) was undertaken for each patient. It enabled staff to identify areas of concern and put care plans in place to improve physical and mental well-being outcomes. We were pleased to see those risk assessments were reviewed regularly and amended as necessary. We were told the ward had a number of laptops available for nursing staff to use in order to update records, but also importantly, those laptops can be taken to patients for one-to-one sessions with keyworkers. This has enabled care and treatment to be assessed and reviewed in 'real time' and offered patients the opportunity to work with their keyworker collaboratively. We recognise the transition from written recording keeping to electronic may take some time to bed-in however we would like to have seen evidence of one-to-one conversations or sessions between nursing staff and their patients. This would have

enabled us to see how patients are day-to-day, to find out whether they had enjoyed specific activities or had days when they required a higher level of staff support.

Use of mental health and incapacity legislation

On the day of our visit, 11 of the 17 patients were subject to Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') legislation. There was evidence that nursing staff had made efforts to support patients with understanding of their rights in relation to the Mental Health Act, however for some patients presenting with a significant impairment of their cognitive functioning, their understanding of their rights and restrictions may be difficult to communicate or understand. To support patients, there is an advocacy service available. Nursing staff can initiate referrals on behalf of patients and advocacy will attend the ward and support patients in relation to Mental Health Tribunal for Scotland hearings. Support can be extended to carers and relatives too.

To ensure nursing staff can carry out care and interventions that are authorised under the legislative framework of the Mental Health Act, and Adults with Incapacity (Scotland) Act 2000 (AWIA), we were told there will be a future commitment for staff to attend training relating to the acts. This is to ensure patients with significant cognitive impairments are supported in terms of their rights and choices in their care and treatment.

We would expect paperwork relating to AWIA legislation, specifically where a patient has a Power of Attorney, to be kept in a patient's file and to be easily available for staff to locate; this is particularly important for agency and bank staff who may not know the patient group, or powers associated with the delivery of care. This is necessary to ensure care and treatment is provided in a legal framework. We were unable to locate AWIA paperwork for one patient.

Recommendation 2:
Managers should ensure paperwork relating to Adults with Incapacity is held and accessible in care records and is accessible to all staff delivering care and treatment to patients.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate under section 47 of the AWIA 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 decision maker and record this on the form. We found one section 47 certificate had expired.

Recommendation 3:
Managers should ensure medical staff undertake regular audits of section 47 certificates and accompanying treatment plans.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed.

For patients who had covert medication in place, all appropriate documentation was in order, with accompanying regular reviews and care plans specific to a covert medication pathway.

The Commission has produced good practice guidance on the use of covert medication which can be found at: https://www.mwcscot.org.uk/node/492

Rights and restrictions

Ward 4 operates a locked door, commensurate with the level of risk identified in the patient group; there is a locked door policy in place.

On the day of our visit there were three patients subject to enhanced observation. This level of observation was required for patients who, following assessment, were noted to require an increased level of staff support and interventions, due to risk. Each patient was reviewed regularly to ensure they did not remain on this level of observation for any longer than necessary.

When we were reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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. As we have previously discussed the majority of patients in this ward would be unable to write their own advanced statement. Nevertheless, to ensure patients are supported to participate in decisions, nurses should be able to evidence how they have made efforts to enable patients to do this and that the rights of each patient are safeguarded.

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 aware that during the pandemic, restrictions that were put in place meant that various activities had to be put on hold, and this included restrictions placed on the number of visitors to the ward. To ensure families and friends were able to keep in touch with relatives, iPads were purchased. Now that restrictions have been relaxed, patients are once again able to see their relatives and where possible, spend time out with the ward.

Each patient had an activity schedule with a meaningful activity planner in place. Patients told us they enjoyed spending time with staff, whether this is engaging in activities such as painting, listening to music together or just "chatting". We were told by patients, and their relatives, that the ward would benefit from access to outdoor space. The lack of a garden that is directly accessible was mentioned to us with patients stating "being outdoors, having fresh air every day would be great". Unfortunately the only available outdoor space was accessed by leaving the ward and using a lift to take patients to the ground floor, where there was a small garden. We heard this was a source of frustration for patients, relatives and staff. New reclining chairs with wheels had been purchased, so patients can be safely moved between the ward, lift and garden with staff support.

The physical environment

During our previous visit to the older adult in-patient wards, we were concerned to find wards that would not be considered "dementia friendly". Dementia friendly wards provide a suitable environment that meets the needs of patients who may be disorientated, present with stress and distress behaviours and have mobility problems associated with older adults. While Ward 4 had reduced the number of beds, the physical environment had not been adapted to meet the needs of patients with dementia or conditions related to cognitive impairment. We would expect to see a ward that takes into account the sensory needs of patients, to include dementia appropriate flooring, lighting, single bedrooms with en-suite bathroom facilities and social spaces for patients to rest or engage in pastimes.

In the large sitting area that also acts as the dining room, we saw toilets for patients to use along one wall. While there were locks on the toilet doors, we were told there have been instances where there had been a lack of privacy due to locks not being used. The sitting room was large, bleak and lacked any home comforts. We were told there is a plan to update the ward, particularly for the bathrooms, which were unsuitable for patients with dementia and who required staff support for their personal care.

The layout of the ward consisted of six single rooms and four shared dormitories. The single bedrooms and dormitories were not personalised and we would like to have seen patients have some possessions that were important to them. The main corridors were stark and bleak, with little or no visible signage, therefore it would be difficult for patients to find their own bedrooms, bathrooms or sitting areas. The flooring in the sitting/dining room was heavily stained, with wear and tear clearly evident. Of the single bedrooms we viewed, while they were functional they would not be considered homely and as patients are likely to be in this ward for a considerable time, we would like to have seen a 'softer' environment.

As previously mentioned, there was no direct access from the ward to a garden or outdoor space. Staff told us they appreciate the benefits of fresh air and gardens as a sensory means to help patients during times of distress. Furthermore, having direct access to outdoor space would enable relatives to visit safely if Covid-19 restrictions were to put in place again. We were told staff make every effort to take their patients to the garden based on the ground floor of the hospital, however this is not always possible and staff appreciated the frustrations this caused for patients.

Staff told us they remained enthusiastic and motivated to provide care for their patients that encompassed a person-centred model and allowed patients to feel safe. They did however feel hampered by the environment and remained frustrated that it was not suitable for patients who had diagnosis of dementia or cognitive impairment conditions.

Recommendation 4:
Managers should address the environmental issues in relation to updating fixtures, fittings, decoration, and maintenance issues.

Recommendation 5:
Managers should ensure that the upgrade programme is regularly reviewed, and attention is paid to maintenance issues that compromise patients' safety and privacy.

Summary of recommendations

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

Recommendation 2:
Managers should ensure paperwork relating to Adults with Incapacity is held and accessible in care records and is accessible to all staff delivering care and treatment to patients.

Recommendation 3:
Managers should ensure medical staff undertake regular audits of section 47 certificates and accompanying treatment plans.

Recommendation 4:
Managers should address the environmental issues in relation to updating fixtures, fittings, decoration, and maintenance issues.

Recommendation 5:
Managers should ensure that the upgrade programme is regularly reviewed, and attention is paid to maintenance issues that compromise patients' safety and privacy.

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
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk