Mental Welfare Commission for Scotland

Report on unannounced visit to:

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

Date of visit: 27 October 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 that is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face and was unannounced.

Ward One is an 18-bedded, mixed-sex ward based in Queen Margaret Hospital. The ward provides assessment and treatment for older adults who have attracted a diagnosis of dementia, including organic-related illnesses. The ward also admits patients with functional illness, including depression and psychosis. On the day of our visit there was one available bed for admission however we told the ward typically regularly reaches capacity.

We last visited this service on 27 October 2016 and made recommendations in relation to the environment and the Mental Health (Care and Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000 documentation, specifically in relation to authorising treatment certificates. We were concerned the ward environment was not fit for purpose and required a full refurbishment.

The response we received from the service at that time highlighted the future plans for the Fife mental health estate across all four hospital sites.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how patients and staff have managed throughout the Covid-19 pandemic and whether the pandemic had continued to cause any long lasting challenges.

Who we met with

We met with and reviewed the care of six patients, whom we met with in person and reviewed their care records. We also met with two relatives and had the opportunity to hear their views about their relatives care and treatment in Ward One.

We spoke with the service manager, the senior charge nurse, the lead nurse and nursing staff throughout the day of this unannounced visit.

Commission visitors

Anne Buchanan, nursing officer

Alyson Paterson, social work officer

What people told us and what we found

Care, treatment, support and participation

Ward one is based in Queen Margaret Hospital; the ward had a dual function in that it admits older adults who have a diagnosis of dementia with significant cognitive impairment, and also older adults with functional illness, including mood disorders and psychosis.

We were told that this dual purpose ward has had some difficulties since early spring this year (2022) with an investigation into the care, the treatment and the culture in the ward; this has been undertaken due to concerns raised by student nurses. There had been a review of all aspects and changes to the staff team. Managers, lead nurses and local authority senior staff had conducted an investigation; however at the time of our visit, this had not been concluded. To ensure patients in Ward One received care and treatment that met their identified needs there was an initial action plan put in place. Progress on the action plan was achieved and the senior leadership team had provided ongoing support and supervision for all ward-based staff. We have received regular updates from the senior leadership team and this unannounced visit was to concentrate on the issues raised by the original complainant, and to consider factors that have influenced the standard of care and treatment.

We heard that recruitment and retention was a concern, with the ward having to rely on agency and bank staff. There were a number of regular bank staff that worked on the ward but this did not replace having a core team who would knew their patients well, had good links with the wider multi-disciplinary team and were able to support carers and relatives. We were told the dual function of the ward had also highlighted the areas where nurses needed to gain additional skills. While there were a number of nurses who had experience of working with both functional and organic illness, there were many who had not and required additional training to ensure the care and treatment met the needs of all the patients in the ward.

We were also informed that patients who had a diagnosis of dementia and who presented with stressed and distressed behaviours would benefit from staff who had a working knowledge of the Newcastle model of care. This model focused upon a largely psychological approach, not only benefitting patients, but also their relatives and staff. This model identifies the possible cause for distress, but also which supportive interventions can reduce behaviours associated with stress and distress. Nursing staff had been encouraged to attend additional training in relation to the Newcastle model, to promote a team approach to care and treatment. To further assist staff and patients, there was a plan to recruit psychologists to embed this model in the older adult wards. While there were a few members of the nursing team who had attended training, there was a recognition that there needed to be a whole team approach for this model to be successful. Any progress will need to ensure all staff, including healthcare support workers, are given opportunities to improve their understanding of working with older adults, who present with cognitive impairment and behaviours that challenge.

Care records

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

number of assessments based upon physical health. Patients in ward one required ongoing assessments based upon a number of areas, including their mental and physical well-being. The Holistic Older Adult Assessment tool was undertaken for each patient. It enabled staff to identify areas of concern and care plans could be put in place to improve physical and mental well-being outcomes. We were pleased to see 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 in 'real time'. We recognise the transition from written to electronic records may take some time to bed-in however we would have liked to have seen more detail of daily contact sessions between nursing staff and their patients. This would have enabled us to see how patients were day-to-day, whether they had enjoyed specific activities or if they had days when they required a higher level of staff support. We discussed this with the leadership team on the day of our visit, especially in light of helping staff who may not be familiar with the ward or patients.

Nursing care plans

Of the records that we reviewed, we were able to identify some care plans that would be considered person-centred; however this was not consistent with all care plans. For those patients who presented with stressed and distressed behaviours, we would liked to have seen an effort to understand specific triggers and interventions to support individuals to reduce their agitation. Also, to ensure participation and to support decision-making, nursing staff should be able to evidence how they have made efforts to do this and that goals that were part of the care plan were clear and attainable. Furthermore, we would have liked to have seen how relatives were encouraged to participate with care planning and how their views were captured in the care planning process. We heard from two relatives who felt the nursing team were welcoming, supportive and who told us that they felt listened to when they needed to speak with staff. Recorded evidence of those discussions would have allowed us to appreciate how care plans were based upon assessments, discussions and input from people who knew the patient well.

We were told there was a quality improvement project underway across mental health in-patient services. This was to consider current practice, information from audits and training needs of nurses working in mental health wards across the Fife in-patient estate. We look forward to reviewing progress from this project during our visits to all in-patient wards.

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 carry out an audit of the nursing care plans 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)
The multi-disciplinary team met weekly to review the care and treatment of each patient. We would have expected to see details of who attended each meeting in each patient record, as well as the patient's progress throughout the week, any actions or intervention needed for progress and which member of the MDT those actions were attributed to. We found that the MDT records were not detailed and we were unable to locate this relevant information. We would also have expected to see how the MDT evidenced patient and relatives participation in the weekly reviews.

Recommendation 2:
The MDT should consider the inclusion of a document that clearly records the key areas of MDT review meetings, including attendance, review of progress, actions, outcomes and patient/relative participation.

We were told there were a number of patients' discharges from hospital based care which were considered to be delayed. We heard that there were significant challenges finding suitable placements or packages of care that would support patients to have successful and sustainable discharges from hospital, but were pleased to hear of the recent appointment of a discharge coordinator to specifically liaise with local authority teams, care homes and colleagues from Fife Health and Social Care Partnership. This new liaison role had assisted with communication between community and in-patient services. There were now regular meetings to ensure any patients whose discharge from hospital was delayed were regularly discussed, with updates communicated to all services, patients and their families.

Use of mental health and incapacity legislation

On the day of our visit, nine of the 17 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). There was evidence nursing staff made efforts to support patients with understanding of their rights in relation to the Mental Health Act, however for some patients who presented with a significant impairment of their cognitive functioning, understanding of their rights and restrictions may be difficult to communicate or understand. There was an advocacy service available to support patients, and nursing staff could initiate referrals on behalf of patients. Advocacy attended the ward and supported patients in relation to Mental Health Tribunal for Scotland hearings, and support could be extended to carers and relatives too.

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. We found that some certificates authorising treatment (T3s) under the Mental Health Act were not in place where required, nor did they always correspond with the medication prescribed. Furthermore, we would advise paperwork accompanying Part 16 of the Mental Health Act should be filed alongside prescriptions, to ensure nurses administering medication know there is legal authority to do so. We could not locate the relevant paperwork and had to ask for copies as part of our review.

Recommendation 3:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular audits to ensure compliance with this is put in place, and that certificates authorising treatment are stored with the prescription kardex.

To ensure nursing staff deliver care and interventions that are authorised under the legislative framework of the Mental Health Act and Adults with Incapacity (Scotland) Act 2000, we were told there was an ongoing commitment for staff to attend training relating to the Acts. This was to ensure patients with significant cognitive impairments are supported in terms of their rights and choices in their care and treatment.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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 decision maker and record this on the form.

We found section 47 certificates that had expired. We were concerned that there did not appear to be an audit process in place to ensure all treatment, including fundamental healthcare, was authorised.

Recommendation 4:
Managers should ensure there are regular audits of Adults with Incapacity (Scotland) Act 2000 certificates and paperwork to ensure relevant care and treatment is authorised.

For patients who had covert medication in place, all appropriate documentation was in order; reviews were recorded, or the pathway where covert medication was considered appropriate. The Commission has produced good practice guidance on the use of covert medication that can be found at:
https://www.mwcscot.org.uk/node/492

Rights and restrictions

Ward one continues to operate a locked door, commensurate with the level of risk identified with the patient group.

When we are reviewing patients' 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. The majority of patients in this unit 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 put in place had 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. As 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. The ward benefitted from having an activities coordinator for two and half days and out with those times, the ward based nursing staff were keen to support patients with recreational and therapeutic activities. Patients told us they enjoyed spending time with staff, whether this was engaging in activities or having opportunities to chat and enjoy each other's company.

There was access to an outdoor space that was shared with one other ward. Unfortunately, this space could not be considered 'dementia friendly' with many trip and fall hazards. There was a lack of comfortable seating with no access to any shelter. The ground on the day of our visit was littered with cigarette ends and the area did little to invite patients to spend time outdoors. We heard this was an ongoing situation and a source of frustration for staff, as they were keen to support their patients to have access to fresh air, and enjoy the opportunities that come with having a 'dementia friendly' therapeutic and recreational outdoor space.

Recommendation 5:
Managers should ensure there is a schedule of works for the ward garden, and that all work required to be carried out is undertaken timeously to enable patients to utilise the outdoor space safely.

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 one 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 have expected to see a ward that took into account the sensory needs of patients, including dementia appropriate flooring, lighting, signage, single bedrooms with en-suite bathroom facilities and social spaces for patients to rest or engage in pastimes.

The layout of the ward consisted of six single rooms and three shared dormitories, each with four beds. The single bedrooms and dormitories were not personalised and we would have liked 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. The single bedrooms that we viewed, while functional, they would not be considered inviting, and as

patients were likely to be in this ward for a considerable time, we would like to have seen a 'softer' environment.

We were told one bathroom could not be used for patients due to risks with the lift mechanism. Another bathroom had been out of action as it was being refurbished, however this was taking a considerable length of time. We saw radiator covers hanging from their hinges, shower facilities that were uninviting, dated and mouldy. While the communal area of the ward, which included the sitting room and dining room, was bright and colourful, there was limited space for patients to sit, or for relatives to meet with them in private without using their bedrooms, if indeed they had the benefit of a single bedroom.

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 were frustrated that it was not suitable for patients who had diagnosis of dementia or for older adults with a functional illness.

We were told by the leadership team there had been a recent ward-based review and inspection of the environment. This included outstanding ligature-reduction work that was yet to be carried out. The review team, including those staff from the estates department were aware of the need for extensive improvement. Furthermore, there was a need to estimate the amount of funding required to ensure this ward, and the other older adult wards, were given the appropriate amount of investment to ensure they are environmentally fit for purpose.

Recommendation 6:
Managers should address the environmental issues in relation to updating fixtures, fittings, decoration, and maintenance issues.

Recommendation 7:
Managers should ensure that the upgrade programme is regularly reviewed, and attention is paid to maintenance issues that compromise patients' safety and privacy.

Any other comments

We were encouraged to hear of the work carried out between the hospital in-patient services and their colleagues in the local authority. The bridge between hospital-based care and moving an individual either back home or into a care home has been difficult to negotiate. With this new role of discharge coordinator there was evidence of good communication between services and any obstacles are acknowledged promptly with strategies put in place to aid transfers of care. We are aware there are ongoing difficulties with sourcing community based packages of care however we felt optimistic with the inclusion of new roles and regular multi-professional review meetings patients will be less likely to remain in hospital unnecessarily.

Summary of recommendations

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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.

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