Mental Welfare Commission for Scotland

Report on announced visit to:

Ward Two, Queen Margaret Hospital, Dunfermline, KY12 0SU

Date of visit: 23 November 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 Two is an adult acute mental health admission ward based in a general hospital in Dunfermline. Prior to the Covid-19 the ward's bed capacity was 29, however this was reduced to 22 beds during the pandemic. Staff at the time of our last visit told us that the decrease in bed numbers had been helpful, as it allowed nursing staff to spend more time with their patients. On this visit, we were informed the bed numbers have increased again to 27; the increase of these additional beds had placed pressure upon the team, particularly as we heard that the acuity of this patient group had significantly increased.

We last visited this service on 30 November 2021 and made recommendations in relation to care planning, access to in-person advocacy, activity provision and the environment. On this visit we wanted to establish whether there had been progress in relation to care planning and whether the environment had received some investment, particularly in relation to bathrooms, shower room doors and outdoor space.

During our last visit to Ward Two, patients told us they found sleeping in dormitories with others distressing. The lack of privacy and noise from other patients made sleeping difficult and added to the stress from being away from home. We were keen to review how patients felt with an increase in bed numbers in the ward's dormitories and whether this increase had an impact on the patients' sense of safety and well-being. We were pleased to be updated in relation to in-person access to advocacy. This had resumed with nursing staff and patients agreeing this provision was hugely appreciated.

We received an action plan from the service that outlined agreed goals for improvement around care planning, taking into account the Mental Welfare Commission's good practice guide for care planning. We were also informed there would be access to funding to improve the ward's environment and timescales for repairs that required urgent attention. Lastly, the provision of activities would be reviewed with the possible addition of a dedicated member of staff to ensure the activity schedule would be achievable.

Who we met with

We met with, and reviewed the care of eight patients, we also had the opportunity to meet with family members of one patient.

In addition we spoke with the service manager, the senior charge nurse, and the lead nurse prior to 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 nursing staff, two consultant psychiatrists and an occupational therapist.

Commission visitors

Anne Buchanan, nursing officer
Tracey Ferguson, social work officer
Alyson Paterson, social work officer

What people told us and what we found

Care, treatment, support and participation

The patients we spoke to were largely positive about their support, care and treatment. We heard the "team couldn't be better" and "the ward has a good atmosphere". However, we also heard a recurring theme. While the nursing staff were praised for their efforts to provide care, they were hampered due to staff shortages. Patients reported this was an issue for them as they knew with more staff they would be provided with additional opportunities for recreational and therapeutic engagement. This was echoed by the leadership team who recognised that while nursing staff attempted to ensure patients were provided with one-to-one sessions and therapeutic engagement, this was not always possible due to competing demands of day-to-day life in a busy acute admission ward. We were told the ward had to frequently depend upon bank nurses, although this had also created difficulties, as bank nurses sometimes failed to turn up for their allocated shifts. This ongoing situation added to pressure on the core nursing team. Despite an increase in bed numbers, and the additional pressures of this, we were told the nursing team remained committed to provide a good standard of care and treatment.

Patients admitted to Ward Two had a consultant psychiatrist, nursing keyworker, and on occasions input from psychology or from allied health professionals, including occupational therapy (OT), physiotherapy and dietician. The team met regularly to discuss progress and invited patients, family members or friends to participate. This offered an opportunity to have an understanding of how care and treatment would aid recovery or whether changes would need to be made to care plans. The patients we spoke to said they felt involved in their care and treatment. They were able to describe the input they had had in identifying their needs and goals and were able to describe the work undertaken with them by allied health professionals. While reviewing patient's care records we would have hoped to see evidence of one-to-one sessions between a patient and their keyworker. We were unable to locate regular one-to-one sessions or detailed descriptions relating to patient's progress in continuation notes. We would like to have seen patient's subjective views documented, especially in light of whether they regarded their admission was meeting their needs and agreed goals to aid recovery.

Recommendation 1:
Managers should ensure continuation notes in patient's files evidence one-to-one sessions with staff and there are detailed accounts of patients' presentations over a 24 hour period.

We reviewed a number of patient care plans and we were pleased to see an improvement. We were told there had been an emphasis on supporting nurses to work with patients to ensure care plans were person-centred and actively encouraged patient participation. Of the care plans we reviewed there was a clear focus upon physical and mental well-being. A holistic approach to care and treatment gave opportunities to ensure that areas which were important to the patient were included in care plans. Furthermore, patients were given their care plans to keep and were invited to review goals and interventions in order to ensure care plans remained relevant throughout their admission. As previously mentioned in this report, Ward Two benefitted from having input from OT. The OT for the ward offered specialist contribution to patient's recovery as they undertook functional assessments, worked together with patients

to create personalised care plans, and also provided support after discharge from hospital-based care.

We spoke with the OT on the day of the visit as we were told by patients how much they valued their input. The remit of the OT is wide, and covers attending ward rounds to provide progress reports, accepting referrals, undertaking assessments and providing specialist input to several patients. Furthermore, this service extended to patients who had been discharged from hospital and required brief follow-up care after discharge. There was a view that additional resources would be welcome, as it was recognised the OT team provided a service that was essential in the patient's recovery.

For patients who required additional support with meal plans, who had specific food intolerances or allergies, we would hope to see a bespoke approach to choices for meals. We were informed this had not been the case for a patient, and it had caused distress as the patient had had very limited menu choices. We were concerned to hear this and spoke with the leadership team, requesting them to address the issue as soon as possible.

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

Multidisciplinary team (MDT)

Ward Two had a range of disciplines accessible to them. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and update on their views. This also included the patient and their families, should they wish to attend. We were told that while it would be beneficial for community mental health team nurses to attend MDT meetings, or discharge planning meetings, this was not always possible due to the competing demands from their services. There were concerns about the absence of community mental health services should a patient experience a crisis. Currently, Fife does not have crisis mental health service for individuals who may require support at home out-of-hours, seven days of the week. We were told patients who experience a mental health crisis at home were likely to be admitted to hospital. There was also an impact on patients who would be considered for early discharge from hospital, as currently they are not able to return home with support from an intensive home treatment model. We were told this was a source of frustration for the team as they recognised patients and their families would benefit from a community support service that would allow patients either to remain at home, or could leave hospital, confident that they will receive intensive support.

We were not able to meet with the ward's mental health peer support worker on this occasion however we heard from staff and patients this role was highly valued. The peer support worker brings their own experience to support patients in the ward, offering a sense of belonging and hope for individual's recovery.

Care records

Information on patient care and treatment was held in the 'MORSE' electronic record system. We found patient records easy to navigate. There was a clear focus upon individual patient's mental and physical well-being, with a number of assessments based upon physical health. Patients admitted to Ward Two required assessments based upon their mental health and well-being, physical health and risks. We were pleased to see 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 could be taken to patients for one-to-one sessions with keyworkers. This enabled care and treatment to be assessed and reviewed in 'real time' and offered patients opportunities to work collaboratively with their keyworker. We would have liked to have seen more detail in patient's records, as this would have enabled us to see how patients presented day-to-day, whether they had enjoyed specific activities, or had days when they required a higher level of staff support. This was important especially if there were nurses working in the ward who were not familiar with the patients, for example bank nurses.

Use of mental health and incapacity legislation

On the day of our visit, 14 of the 27 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). The patients we met with during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act.

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 not all of the consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, nor did not correspond to the medication being prescribed. We found several cases where prescribed medications were missing from treatment certificates, T2 certificates that had some treatments included but other treatments were missing, and T3 certificates that could not be located; treatment would be considered not to be legally authorised under the Mental Health Act as a result of this.

We advised the senior leadership team that as a matter of urgency, patients who did not have their treatment authorised must be notified formally, as should the patient's named person. We were concerned there was not a governance process in place to ensure all treatments were prescribed and authorised with the legal framework of the Mental Health Act.

Recommendation 2:
Managers and the responsible medical officers must ensure that all psychotropic medication is legally authorised and record a clear plan of treatment. Regular audits should be undertaken to ensure correct authorisation is in place.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Rights and restrictions

Ward Two continues to operate a locked door, however we were unable to locate a 'locked door policy'. We heard that while the door to the ward should be locked, patients had left the ward without staff knowledge. We heard from relatives this was distressing and was an additional stressor they had not expected when their family member was admitted to hospital. We were informed that this had occurred on several occasions, again without staff knowledge and required staff to take active steps to locate the individual. We were told by senior managers that the door to the ward is due to be replaced with an 'airlock' entry system, and that this will provide additional safety and security. We raised our concerns about the absence of a locked door policy, patient's security in and out of the ward, and the delay in improving the current door entry system.

Recommendation 3:
Managers should put in place a 'locked door policy', ensuring the policy is easily accessible to patients and visitors.

Recommendation 4:
Managers should ensure the ward's door entry system is fit for purpose to reduce potential risks to patients and staff.

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 this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act we found reasoned opinions in place.

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

When we are reviewing patient files we looked for copies of advanced 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 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

When we last visited Ward Two, we heard from patients that they often felt bored during their admission to hospital. For this visit we were informed that this was still the case, and with an additional number of patients admitted to the ward, there was a sense nursing staff were often very busy and recreational activities were not undertaken. Patients appreciated the input from the ward's OT and valued the activities that were available, however they would have welcomed more opportunities for recreational and therapeutic engagement. The younger

patients felt activities did not take account of their interests, and they were often left to their own devices and which meant that the days were long and dispiriting. This was a significant concern for patients who did not have opportunities to have time off the ward or have regular visitors. Ward Two does not have an activities coordinator or a dedicated member of the team to provide opportunities for recreational and therapeutic engagement. We were told there was a work force planning review to consider the appointment of support workers, to adopt a well-being and enablement model to enhance therapeutic engagement. We have asked the leadership team to update us with progress as the absence of timetabled activities was discussed by all patients we met with on the day of our visit.

Recommendation 5:
Managers should review activity provision in Ward Two and consider options for providing opportunities for recreational and therapeutic engagement while workforce planning is being reviewed.

The physical environment

There were four dormitories equally split between male and female patients. There were six single bedrooms with an en-suite toilet. As mentioned earlier in this report there had been an increase in bed numbers and dormitories that previously had four beds now have five. We were told by patients sleeping in dormitory-style bedrooms that this was stressful. Patients had to share one bathroom for each dormitory, including shower facilities, and these required updating. We saw mould around flooring in the showers and creating the appearance that they were unhygienic.

During our last visit we raised concerns about the doors to the patient's shower rooms. We were pleased to see the doors had been replaced, however patients complained about the lack of privacy as there were no locks on the bathroom doors. Patients felt the washing facilities lacked privacy, safety and dignity.

We were concerned to see anti-ligature work has not been completed with a number of areas in the ward that would be considered a significant risk.

We were also concerned about the public areas of the ward, namely the floor coverings in the main corridor that were old, torn and held down with tape. The ward had a communal area for socialising and mealtimes, this area was bright and well maintained. There had been investment to have art work created by patients attached to the walls that gave the room a welcoming impression.

The ward had direct access to outdoor space, and while there had been attempts to soften the environment, it remained stark and uninviting. On the day of the visit we saw patients use the area primarily for smoking, with the ground littered with cigarette ends. For non-smokers or visitors this may add to the unappealing character of the outdoor space and overall it appeared neglected.

We were told there had been several meetings with senior staff including individuals from the planning service to consider the upgrading required for Ward Two. This is likely to require patients to be moved to other wards, such is the extent of the refurbishment. There was no current schedule for this work to start and no agreement in terms of the necessary funding

required. We were told by patients the environment lacks the essentials for a therapeutic setting and basic washing facilities are unacceptable. We consider the refurbishment of Ward Two as essential.

We raised concerns about the environment previously and were informed improvements would be made, however this had not been followed through with any significant difference noted. We have requested to be updated regularly with decisions in relation to a schedule for work to be carried out and whether funding has been made available to ensure all necessary updates can be completed.

Recommendation 6:
Managers should address the environment 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 patient's safety and privacy.

Summary of recommendations

Recommendation 1:
Managers should ensure continuation notes in patient's files evidence one-to-one sessions with staff and there are detailed accounts of patients' presentations over a 24 hour period.

Recommendation 2:
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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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