Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 1, Queen Margaret Hospital, Whitefield Road, Dunfermline, KY12 0SU

Date of visit: 7 September 2023

Where we visited

Ward 1 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 regularly reaches capacity.

We last visited this service in October 2022 and made recommendations in relation to care planning, evidence of a multidisciplinary model of care and opportunities for each member of the team to confirm their role and responsibilities. We found during our last visit that patients who required their treatment to be authorised under a legal framework, for example Mental Health (Care and Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000 had missing treatment forms. Lastly, we raised significant concerns about the environment; we found the ward was not conducive to meeting the needs of patients who were admitted with dementia and cognitive impairment related conditions.

We received a detailed response from the service in early 2023 with a schedule of remedial work to the environment to be undertaken from that time.

On the day of this visit we wanted to follow up on our previous recommendations and also to hear how staff had embarked upon their improvement plans for the environment; and promoting person-centred care, which included enhancing nursing staff's knowledge and skills. We also wanted to hear about the impact of the addition of a psychological framework for Ward 1, as it now benefitted from access to a psychologist and music psychotherapist.

Who we met with

We met with, and reviewed the care of seven patients, and we also had the opportunity to meet with relatives.

We spoke with the service manager, the senior charge nurse, charge nurses, the lead nurse, psychologist, art psychotherapist, and consultant psychiatrist.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Tracey Ferguson, social work officer

Denise McLellan, nursing officer

What people told us and what we found

We met with several members of the multidisciplinary team in Ward 1 who were keen to tell us how they enjoyed working in the ward. We heard that "It is fantastic to work here" "the difference a year can make is great; the new senior leadership team have made all the difference". We were told by patients that we met with that staff were "always friendly" however at times the ward could feel rather overwhelming, with some patients going in and out of other patient's rooms. When we asked relatives about their experiences, they told us that "communication is excellent, staff are too".

Care, treatment, support, and participation

During our last visit to Ward 1, we found that care and treatment lacked a multidisciplinary model or approach. We had difficulty locating care plans that would be considered person-centred and we were concerned the team were not taking an active approach to supporting patients with complex needs. On the day of this visit, we were pleased to find a multidisciplinary team that had a clear focus and were working collaboratively to ensure their patients were provided with personalised, bespoke care and treatment.

Patients admitted to Ward 1 required robust psychological and physical health assessments with individualised care planning thereafter. Often patients were admitted from their own home having been cared for by family. The team recognised that working with families was essential to promote a sense of understanding of a patient's specific needs and to meet the expectations of families and carers. To further support families, the team ensured that relatives were provided with information in relation to diagnosis and signposting to organisations that provided support for carers too.

We were keen to review care plans, as during our last visit to Ward 1, we were concerned care planning lacked focus and would not be considered person-centred. We reviewed several patient's care records and found excellent examples of care plans, particularly those related to supporting patients who presented with stress and distress. There was evidence of a clinical team that had adopted a psychological model of assessment which had taken into account a patient's former life, pre-diagnosis, and how the team could support patients to reduce potential triggers that may cause stress and distress. While we recognised for some patients participating in, or collaborating in the preparation of their care plans would be difficult due to the level of cognitive impairment, we could see evidence of how the nursing team had supported patients with some decision-making. Furthermore, we also saw evidence of how nursing staff had invited relatives to consider care and treatment, with an open dialogue that encouraged participation.

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

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Multidisciplinary team (MDT)

There were a number of disciplines providing input to patients in Ward 1, including nursing, a consultant psychiatrist, psychology, music psychotherapy and weekly visits from physiotherapy. Referrals to other allied health professionals, including occupational therapy, dietician and podiatry could be made, with referrals accepted without issue.

With the recent addition to the ward-based team of psychology and music psychotherapy, we were told this has had a positive impact upon the patients' presentation. While there were still some episodes of stress and distress for patients, this has significantly reduced. A model had become embedded that assessed patients' psychological presentation and how this affected their communication, emotional well-being, and social interactions with peers and staff. Furthermore, the team had taken an active role to ensuring patients' physical well-being was assessed and early identification of discomfort or pain was managed, to ensure patients were comfortable and able to rest accordingly. We were told having one consultant psychiatrist to provide input for the ward had greatly improved communication and consistency. Nursing staff had been encouraged to attend additional training and were supported regularly with reflective practice sessions with the visiting psychologist. The nursing team told us with additional knowledge and skills, they felt more confident with providing care and treatment that was specific to the needs of their patients.

Patients admitted to Ward 1 for assessment would likely require their care and treatment to be transferred to either a longer stay inpatient ward or nursing home. Often transfers of care to nursing homes could take time to arrange, therefore additional input was required from inpatient services and the local authority. The ward-based team were supported by a discharge coordinator who took an active role to ensure patients who required nursing home placements did not remain in the ward for a protracted period of time. This role had been welcomed by the team as it had helped patients and staff to stay focussed on improved outcomes for patients and their families.

Care records

Patient information was held on Morse, an electronic record keeping system. We found care records easy to navigate and with the inclusion of all disciplines inputting information, we were able to see which member of the team was delivering specific interventions, outcomes, and progress. We were pleased to see there was a focus upon patients' physical well-being. We were told by the team it was essential to identify discomfort or underlying physical problems that could often be the consequence for stress and distress presentations. We would like to have seen greater detail in the daily continuation notes. Whilst we could identify improvements in record keeping, having the benefit of a richer daily narrative would help the reader have a greater understanding of how patients present throughout the day. We raised this with senior nursing staff on the day of the visit and they agreed to work with the team to ensure daily notes were informative.

Use of mental health and incapacity legislation

On the day of our visit, there were a number of patients in the ward who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). There was evidence that 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 would have been 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place, where required, and corresponded to the medication being prescribed. We found that all T3 certificates that had been completed by the responsible medical officer to record non-consent were available and up-to-date.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 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. On the day of the visit, we became aware that staff may need additional knowledge in relation to the AWI Act. It is important for all staff to understand when a s47 is required and in terms of the accompanying treatment plan, what interventions are legally authorised. For this reason, we suggested all staff should undertake eLearning modules that were available to them. Those can be located through NHS Scotland TURAS digital platform and are available for all professionals employed in NHS Scotland.

For patients who had covert medication in place, all appropriate documentation was in order, and records of reviews were in place.

Rights and restrictions

Ward 1 continued to operate a locked door, commensurate with the level of risk identified with the patient group. A locked door policy was in place.

When we reviewed 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 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

With new members of the multidisciplinary team joining Ward 1, there appeared to have been an increase of psychological well-being of every patient. Psychology and music psychotherapy were now embedded in the care and treatment offered to patients and also provided opportunities for nursing staff to work with a new model of care delivery. Patients also had opportunities to engage with a skilled activities coordinator, who provided an imaginative programme of activities for every patient. While some patients may enjoy group activities and thrive in the company of others, for other patients this is less enjoyable. Therefore, the activities coordinator was also able to provide bespoke one-to-one activities for therapeutic and recreational engagement.

The physical environment

Following our visit to Ward 1 last year we made three recommendations in relation to the environment. We were concerned that bedrooms, bathrooms and communal areas of the ward appeared tired and neglected. We had received updates from the leadership team over the last year to advise us that funding had been secured to commence a programme of environment improvements and updating fixtures and fittings.

We were delighted to see the progress the team had made to the ward environment. With attention to detail the ward had become a bright, welcoming, and therapeutic space for patients and staff. Staff told us the environmental improvements had made a considerable impact upon patient care and patients had presented with less stress and distressed behaviours. The benefit of sensory equipment and space had allowed patients to engage with therapeutic activities and had given staff opportunities to support patients without pharmacological interventions, thus reducing risks from falls and associated hazards. The ward-based team had plans to improve the outdoor space to ensure the garden was accessible for patients and their families. The team recognised that whilst there had been significant improvements, they wished to extend the therapeutic space further by introducing a café and inviting carers and relatives into the ward to use the new facilities.

Any other comments

We wish to acknowledge the time and commitment the team have shown over the last 12 months to improve patients' experience. We fully recognise that any improvements take determination and while Ward 1 was a busy ward, the team have demonstrated their commitment to changing their model of care to ensure patients and their families are welcomed and valued.

With an introduction of psychology, music psychotherapy, and a commitment from the leadership team to ensure nursing staff were skilled and knowledgeable, we were delighted to observe a ward that had made significant improvements and look forward to seeing further progress during our next visit.

Service response to recommendations

The Commission made no recommendations, therefore no response is required.

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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