Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 9 November 2023

Where we visited

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 15 individuals and three empty beds. Those admitted to Ward 4 typically have a diagnosis of dementia related conditions.

Ward 4 is considered a transitioning ward for older adults who will be returning home with packages of care to support their discharge or move into long term placements in care homes. We were told by the clinical team that those admitted to Ward 4 have complex needs both in relation to their mental health and physical well-being, and require a high level of support from nursing and allied health professionals.

We last visited this service in September 2022 and made recommendations in the areas of care planning, the Adults with Incapacity (Scotland) Act 2000 (the AWI Act,) specifically for staff to understand the need for safe storage of paperwork and their knowledge of the AWI Act. We also highlighted our concerns about the ward environment. On the last visit we identified several areas that required updating and remedial work to make the ward fit for purpose.

Following the visit to Ward 4, we received a detailed action plan and have received regular updates from the senior management team in relation to the ward's environmental improvement upgrade.

Who we met with

We met with six patients and had the opportunity to review their individual care records. We also met with four relatives on the day of our visit and received written feedback from a further two relatives.

We spoke with the service manager, the senior charge nurse, and the lead nurse prior to the day of our visit and had further opportunities to meet with and listen to the views of the ward-based team on the day of our visit, including allied health professionals.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

Kathleen Liddell, social work officer

Denise McLellan, nursing officer

What people told us and what we found

We met with several individuals who were keen to tell us they were happy with their care and treatment; they had found nursing staff to be “very caring and attentive”. We recognised for some that being in hospital could be a relatively new experience and that being away from home could be a challenge. Individuals told us there was “always a lot to do” and enjoyed spending time in the company of staff while undertaking ward-based activities. We met with several relatives, and their feedback was largely positive. However, some relatives had found their experiences had been problematic, with communication being the source of frustration for them. Those that we spoke with were keen to be involved with their relatives care and treatment, often having cared for their relative prior to their hospital admission. Having opportunities to be an active participant during discussions in relation to care planning, receiving updates in terms of progress and concerns about physical health care were themes the relatives wished to bring to our attention.

We also had an opportunity to meet with several members of the ward-based nursing team and allied health professionals who provided input into the ward. Staff were keen to tell us they had noticed the improvements in the environment and that this had had a “big impact” upon their motivation, enthusiasm and had felt valued in their roles. The ward was a “great place to work in” and felt like a therapeutic space for everyone.

Care, treatment, support and participation

During our last visit to Ward 4, 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 individuals with complex needs.

On this visit, we were pleased to find a multidisciplinary team that had a clear focus and were working collaboratively to ensure individuals were provided with personalised, bespoke care and treatment. We were pleased to find risk assessments directly influenced care plans, with all assessments having a holistic approach that considered an individual’s complex needs and interventions required to meet those needs. To ensure participation and supported decision making, nurses should be able to evidence how they have made efforts to do this. We recognised that for some individuals, being an active participant in their care planning may be difficult such was their cognitive decline. We therefore would have liked to have seen how relatives were invited to collaborate with developing care plans. Relatives we spoke to identified this as an issue for them; we brought this to the attention of the ward-based leadership team.

We were keen to review care plans, as during our last visit to Ward 4 we were concerned care planning lacked focus and would not be considered person-centred. We reviewed several care records and found excellent examples of care plans, particularly those that related to supporting patients who presented with stress and distress. There was evidence of a clinical team who had adopted a psychological model of assessment that had considered an individual’s former life, pre-diagnosis and how the team could provide support to reduce potential ‘triggers’ that may cause stress and distress. In care records we enjoyed reading an initial introduction to the individual. This allowed the reader a greater understanding of the

person as an individual, what was important to them, their likes and dislikes and a brief social history.

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)

Care and treatment was provided by a multidisciplinary team (MDT) including medical and nursing staff, occupational therapy, speech and language therapy, physiotherapy and there is input from older adults' community mental health teams.

Other disciplines providing input to Ward 4 alongside the nursing team, is a consultant psychiatrist, psychology, and music psychotherapy. 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 individuals' presentation. Whilst there were still some episodes of stress and distress, this had significantly reduced. A model has become embedded that assesses individuals' psychological presentation and how this affects their communication, emotional well-being, social interactions with peers and staff. Furthermore, the team had taken an active role to ensuring physical well-being is assessed, and early identifications of discomfort or pain is managed, to ensure individuals are comfortable and able to rest accordingly. We were told by nursing staff that they had identified several individuals who required significant support to maintain their physical well-being. Allied health professionals, including a dietician and speech and language therapy have become embedded in the ward team such is the complexity of patient's presentations.

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 those individuals in Ward 4.

For some people admitted to Ward 4, they may require their care and treatment to be transferred to either a longer stay inpatient ward or to nursing home. Often transfers of care to nursing homes could take time to arrange, therefore regular communication between relatives, local authority and nursing homes was essential. The ward-based team were supported by a discharge coordinator who took an active role to ensure those who required nursing home placements did not remain in the ward for a protracted period. This role had been welcomed by the team as it had helped everyone to stay focussed on improved outcomes for individuals and their families.

Care records

Clinical 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 each individual's 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 individuals presented 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 more informative.

Use of mental health and incapacity legislation

All documentation relating to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) was in place and easily located in patient's care records.

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. We found that all T3s had been completed by the responsible medical officer to record non-consent; they 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) 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 copies of section 47 certificates that lacked evidence of discussion with either a legal proxy, for example welfare attorney or next-of-kin. We reminded the ward leadership team of the statutory responsibility of this and the importance of working to the Adult with Incapacity Act code of practice for medical practitioners.

Recommendation 1:
Managers should ensure an audit of all section 47 certificates to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion or agreement is recorded.

For patients who had covert medication in place, all appropriate documentation was in order, with recording of reviews evident. 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

The Scottish Government produced a revised policy on do not attempt cardio-pulmonary resuscitation (DNACPR) in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf). This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to

a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded.

DNACPR forms were completed with evidence of discussion with nearest relative or proxy, as appropriate. We brought to the attention of the ward-based leadership team that reasons for decisions not to administer CPR need to be clearly documented on forms to ensure those decisions have been thoughtfully considered.

Rights and restrictions

Ward 4 continues to operate a locked door, commensurate with the level of risk identified with the patient group. There was a locked door policy in place and an information notice available at the ward's entrance, which referenced this.

When we are reviewing patients' files, we look 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. Most individuals in this ward would be unable to write their own advanced statement. Nevertheless, to ensure they are supported to participate in decisions, clinical teams should be able to evidence how they have made efforts to enable individuals to do this and that the rights of each person are safeguarded.

We were told advocacy support services were available and referrals on behalf of individuals were responded to without delay and staff appreciated their input.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that people 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 4, there appeared to have been an increase of psychological well-being of every individual in the ward. Psychology and music psychotherapy were now embedded in the care and treatment offered and provided opportunities for nursing staff to work with a new model of care delivery. Individuals also had opportunities to engage with a skilled activities coordinator, who provided an imaginative programme of activities for everyone on the ward. While some individuals may enjoy group activities and thrive in the company of others, for others, this was less enjoyable. Therefore, the activities coordinator was also able to provide bespoke one-to-one activities for therapeutic and recreational engagement.

The ward has had the opportunity to purchase an array of new equipment specifically designed to support individuals with dementia and related conditions. While the equipment could be used independently and was accessible for every individual, it was also used to promote therapeutic engagement between staff and individuals. The nursing team told us this

level of engagement had improved. Sharing experiences had allowed staff to work with people and had notably reduced episodes of stress and distress for many individuals on the ward.

The physical environment

Following our visit to Ward 4 last year we made two recommendations in relation to the environment. We were concerned 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 all. Staff told us the environmental improvements had had a considerable impact upon care delivery and individuals in the ward had presented with less stress and distressed behaviours. The benefit of sensory equipment and space had allowed individuals to engage with therapeutic activities and had given staff opportunities to offer support, without using 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 individuals and their families. The team recognised that whilst there had been significant improvements, and they wished to extend the therapeutic space further by introducing a café and invite carers and relatives into the ward to use the new facilities.

Any other comments

We wish to acknowledge the determination from the leadership team and the ward-based team with their efforts to improve the environment and thus the care experience for individuals in the ward. There had clearly been investment to update the ward, provide new sensory equipment and encourage the team to attend training to increase knowledge and skills. There had also been a swing towards supporting staff's well-being, which was important, as it confirmed the team were valued. We were told Ward 4 was a pleasant place to work, and that the ward felt more relaxed with a significant improvement in engagement between nursing staff and individuals in the ward. We look forward to visiting the ward next year to see the progress with their plans for the new café for patients and visitors.

Summary of recommendations

Recommendation 1:
Managers should ensure an audit of all section 47 certificates to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion or agreement is recorded.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication 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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