Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 2, Queen Margaret Hospital, Whitefield Road, Dunfermline, KY12 0SU

Date of visit: 16 November 2023

Where we visited

Ward 2 is an adult acute mental health admission ward, based in a general hospital in Dunfermline. The ward can accommodate 30 individuals; on the day of the visit there were 26 individuals. We were told the ward often reaches capacity, and for individuals and staff, this can be a challenge as the ward continues to have a mix of dormitory style bedrooms with a small number of single bedrooms. With a lack of space, individuals were often having to sleep in dormitories that accommodate six beds.

We were keen to speak with individuals and staff about the environment in Ward 2, as we were told during our last visit this was a source of frustration and stress for some individuals and a daily challenge for ward-based staff.

Who we met with

We met with 10 individuals and reviewed their care records. We also met with one relative.

We spoke with the service manager, the lead nurse, the senior charge nurse (SCN), both charge nurses and consultant psychiatrists. We also had the opportunity to meet with the music psychotherapist and student nurses on placement in Ward 2.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Gordon McNellis, nursing officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

Individuals we met with on the day of the visit provided feedback that varied in terms of their experiences in Ward 2. For some individuals their experiences were mainly positive; the staff were described as “brilliant”, “restored my faith in mental health services”, “the ward feels safer than before, it feels different”.

However, for some individuals they felt the “ward is too busy, no space to retreat to when it’s noisy”, “getting to sleep is difficult, can’t cope with five other people in a dorm, it’s really stressful”, “lack of privacy in the dorms, it doesn’t feel safe at times”.

For some individuals they told us they felt very involved in their care and treatment, were able to discuss their goals for the admission to hospital and were working towards recovery as a shared experience between the clinical team and themselves. However, this experience was not shared by everyone. Individuals told us feeling involved with decisions about their care and treatment was important to them, however with some, decisions were being made without discussion, and for some, they were left with a sense of not being part of their treatment.

When we visit wards, we like to gather the views of a variety of individuals. On this occasion we were pleased to meet with a number of people, including student nurses on placement. We heard that their experience was extremely positive; we were told they had felt they were valued members of the team and were provided with a variety of learning opportunities. For student nurses having opportunities to consolidate their theoretical knowledge was a significant part of their positive view of the ward.

During our last visit to Ward 2, we made recommendations in relation to daily record of individual’s progress in care records, governance around legally authorising treatment, activity provision and maximising opportunities for therapeutic engagement. We were concerned about the ward environment, particularly for individuals who required a safe and therapeutic setting during their admission to hospital. We received updates throughout the year and an action plan that identified areas as requiring improvement.

Care, treatment, support and participation

We were pleased to have found individual’s care plans had a clear focus upon mental health and physical well-being. We found care plans to be of a good standard, with several having evidence of individuals’ participating with the process of identifying needs, goals and interventions to aid recovery.

While we were able to identify several care plans that would be considered person-centred, this was not consistent across all care plans we reviewed. We found an excellent document that ‘set the scene’ for each individual. This document captured key information about the individual, their social circumstances and what was important to them. This offered opportunities for each member of the ward-based team to recognise individuals’ strengths and the purpose of the admission. While there were several care plans that were very detailed, there were care plans that would have benefitted from greater participation from individuals who were receiving care and treatment. Furthermore, having the benefit from input with allied health professionals (AHPs) such as occupational therapy, or music therapy, may have given

care plans a bespoke narrative for each individual. We would also like to have seen a greater emphasis on care plan reviews.

There were some where reviews were completed, but this was not always consistent. Care planning is not a static process. For some individuals, recovery may take some time with several interventions required to aid recovery. For others, recovery may be a speedier process that only requires a brief admission to hospital. Regular care plan reviews allow for the efficacy of interventions to be identified through assessment, and to be evaluated on whether they are providing the support necessary to promote mental well-being.

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

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

We also brought to the attention of senior nurses the use of descriptive language that nursing staff had written in individuals' care records. We would expect written communication to be objective, considerate, and professional. On occasion we found descriptions of individuals' presentations that fell short of the Nursing and Midwifery Council (NMC) standards for record keeping. We saw, in continuation records, language that could have been considered pejorative, rather critical and judgemental. This appeared to have been the opposite of the work that had been undertaken by nursing staff to support individuals, who by virtue of their illness, often had considerable difficulties with emotional regulation.

Recommendation 2:
Managers should undertake regular audits of care records to ensure all written communication meets the Nursing and Midwifery Council standards for record keeping.

Multidisciplinary team (MDT)

Ward 2 had a range of professionals providing input into the ward. With consultant psychiatrists and mental health nursing staff typically providing care and treatment, the ward also benefitted from allied health professionals (AHPs) providing support throughout the week. Individuals told us they had welcomed the appointment of a music therapist, who provided one-to-one therapy along with group work. Occupational therapy was also highly valued. There were five consultant psychiatrists with no substantive medical staff. All consultants were locums, albeit there were several who had been in their locum positions for a few years. We enquired whether this was likely to continue; unfortunately recruiting into permanent consultant psychiatry posts remained a challenge for adult mental health services.

AHPs provided input, included physiotherapy, speech and language therapy and dieticians. All referrals to services were met promptly with AHPs providing updates to the ward-based team. The MDT met weekly to review and discuss individuals' care, treatment and progress. Individuals and their relatives were invited and supported to attend meetings. There was a

recognition that not all individuals wished to attend review meetings, therefore their views were sought prior to the weekly meeting. We were pleased to have found the reviews for the weekly MDT meetings were detailed and included updates from all professionals, individuals and their relatives. We were also pleased to hear that community mental health teams (CMHTs) took an active role with keeping in touch with individuals who were known to community mental health nurses. Keeping in touch and participating with MDT meetings was considered essential to ensure the pathway from admission to discharge was clearly communicated to community teams.

However, there remained concerns about the absence of a crisis community mental health service, should an individual experience a crisis in the community. Fife HSCP did 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 individuals who experienced a mental health crisis at home were likely to be admitted to hospital.

There was also an impact on individuals who would be considered for early discharge from hospital, as currently they were not able to return home with support as there was no intensive home treatment model. We were told this was a source of frustration for the team as they recognised individuals and their families would benefit from a community support service that would allow individuals either to remain at home, or could leave hospital, confident that they would receive intensive support. We were told as part of an over-all review of mental health services in Fife there were discussions to consider a 'crisis/home treatment' model.

We would welcome updates from the service as we were told this would be an important and essential provision for individuals living in Fife.

Care records

Information on individual care and treatment was held in the 'MORSE' electronic record system. We found individual records easy to navigate. There was a clear focus upon individuals' mental and physical well-being.

Individuals admitted to Ward 2 required assessments based upon their mental health, physical well-being, and risks. Assessments varied in their detail; while several offered the reader a good understanding of risks and care needs for the person, there were several that lacked specific details of who would be providing support and the reasons for this. We would like to have understood that where risks were identified, what measures had been put in place to support the individual, and how risks that may have impacted upon others were managed safely.

We would have liked to have seen more detail in individuals' care records; this would have enabled us to appreciate how individuals presented day-to-day, whether they had enjoyed specific activities or, if there had been days where 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 individuals, for example bank nurses.

Recommendation 3:
Managers should consider auditing care records, specifically risk assessments to ensure the quality reflects information gathered throughout an individual's admission. Where risks have been identified, those are communicated, and safety plans are put in place.

Use of mental health and incapacity legislation

On the day of our visit, a number of those in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained people, who are either capable or incapable of consenting to specific treatments. We found that 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 T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date.

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

Rights and restrictions

Ward 2 continued 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 available to all visitors on entering the ward.

Individuals who we met with during our visit, and who were subject to detention under the Mental Health Act, had a variable understanding of their detained status. We were aware of some individuals who were receiving their care in hospital informally. Those individuals were not as clear as to whether they were subject to any restrictions, for example, having time off the ward without the need for staff to escort them. We highlighted this on the day of our visit, as it was an example of the ward-based team's requirement to ensure that all individuals, whether they were subject to legislation or receiving their care informally, needed to understand their rights, and what restrictions were placed upon them and the reasoning for this.

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 an individual 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.

When we reviewed individuals' files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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. We were pleased to see several individuals had made their views known by completing an advance statement and copies of those were held in their care records.

All individuals admitted to Ward 2 have the right to advocacy services; this service was available throughout the week and was highly valued by individuals who sought their support.

Recommendation 4:
Managers should ensure all individuals admitted to inpatient services are made aware of their rights, whether an individual is subject to Mental Health Act legislation or is receiving their care and treatment informally.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals have their human rights respected at key points in their treatment.

Activity and occupation

We were told by several individuals they had regular input and support from a range of AHPs. A recent appointment of a music therapist had complimented the ward's multidisciplinary team and had provided a psychological approach to care and treatment through the medium of music.

Additional support, assessment and treatment continued to be provided by occupational therapy. Again, occupational therapist had a valuable role to provide individuals with formal functional assessments along with recreational and therapeutic engagement. We also understood that the highly regarded peer support worker had moved on from their post. We were told there were considerations to recruit into this role, as people admitted to the ward had found this supportive role to have been essential to their recovery.

We would like to have seen evidence of when activities had taken place, who had participated in what, and whether those activities had been beneficial to an individual's daily routine. We recognised an activity, whether in a 'formal' sense or recreational, provided the opportunity for engagement between individuals and the ward-based team. Knowing whether activities influenced recovery would have been helpful, therefore we highlighted this to the ward-based team on the day of the visit.

We were told the service recognised the value and importance of therapeutic engagement and had funding to recruit 11 new activity co-ordinators across all inpatient services. Interviews for these posts were due to take place imminently and we look forward to meeting the new staff during our future visits.

The physical environment

Since our visit to Ward 2 last year, there have not been any significant improvements to the ward or the environment. The ward continues to admit to its capacity, and above. This was significant, as it meant individuals continued to sleep in dormitory style accommodation that was neither appropriate for the individual population, nor large enough for people to have the room and space that individuals needed to feel comfortable.

We were told by individuals the ward was not therapeutic, that it was often very noisy, and in turn increased stress and anxiety. Whilst not the case for every person we met with, it was the reported experience for several people as they felt their admission was prolonged due to the ward milieu.

The ward had six single bedrooms with en-suite toilet facilities, there were four dormitories that accommodated six individuals per dormitory. With little privacy between beds, a curtain around each bed and, with windows into the main corridor of the ward; we were told this added to individuals' lack of dignity and increased levels of stress.

The ward had one large area that was used for various activities including watching television, as a dining room and for recreational activities, including music therapy. We were told that while the room was bright and airy, it was not necessarily a space individuals would use should they wish some quiet time. The only other room available was not warm or welcoming and was very rarely used for this reason.

We visited the garden to find out whether progress had been made to promote it as a therapeutic and recreational space. We were disappointed to find it appeared to be only used for individuals to smoke cigarettes or 'vape'. We found a large number of cigarette ends, litter and smoking debris all over the ground. As the door to the garden was accessed through the sitting/dining room, we were aware of the strong smell of cigarette smoke and vaping odour that was in the sitting room where individuals ate their meals, engaged in therapy and attempted to relax. We were told by individuals we met with that this caused significant stress, particularly for those who were non-smokers or were attempting to stop smoking.

The environment required significant updating in terms of fixtures and fittings, as the floor coverings were torn, and held in place with tape. While the nursing team, along with individuals in the ward had made murals for the main corridors, the ward lacked any home comforts or warmth. Individuals told us they would welcome additional space in the ward, places where they could relax, listen to music or read however; presently this was not possible. Due to dormitory style bedrooms, having an opportunity for privacy and relaxation was a challenge.

We were told the ward had been highlighted as an area requiring significant investment. While we were reassured that Fife HSCP recognised this, we were concerned that timescales for work to be undertaken may not be in the immediate future therefore, individuals admitted to Ward 2 would continue to be disadvantaged in terms of well-being, privacy and dignity.

Recommendation 5:
Managers should ensure any remedial work, updating of fixtures and fittings is undertaken as a matter of urgency. This should also be extended to the outdoor space, attention to the upkeep of this space is essential.

Recommendation 6:
Managers should consider whether having a ward that can accommodate up to 30 individuals is suitable for people who present with significant mental ill-health.

Recommendation 7:
Managers should consider whether having six bed spaces for each dormitory supports individuals' needs for safety, privacy and dignity.

Summary of recommendations

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

Recommendation 2:
Managers should undertake regular audits of care records to ensure all written communication meets the Nursing and Midwifery Council standards for record keeping.

Recommendation 3:
Managers should consider auditing care records, specifically risk assessments to ensure the quality reflects information gathered throughout an individual's admission. Where risks have been identified, those are communicated, and safety plans are put in place.

Recommendation 4:
Managers should ensure all individuals admitted to inpatient services are made aware of their rights, whether an individual is subject to Mental Health Act legislation or is receiving their care and treatment informally.

Recommendation 5:
Managers should ensure any remedial work, updating of fixtures and fittings is undertaken as a matter of urgency. This should also be extended to the outdoor space, attention to the upkeep of this space is essential.

Recommendation 6:
Managers should consider whether having a ward that can accommodate up to 30 individuals is suitable for people who present with significant mental ill-health.

Recommendation 7:
Managers should consider whether having six bed spaces for each dormitory supports individual's needs for safety, privacy and dignity.

Service response to recommendations

The Commission requires a response to these recommendations 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.

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