Mental Welfare Commission for Scotland

Report on announced local visit to: Ward 2, Queen Margaret Hospital, Dunfermline KY12 0SU

Date of visit: 6 March 2019

Where we visited

Ward 2 is an acute admission psychiatric ward. It is based in a general hospital in Dunfermline and is a 30-bedded facility. The ward covers a large catchment area of West Fife and is supported by five consultant psychiatrists. It is a mixed ward and has two male dormitory areas, two female dormitories and six side rooms. On the day of our visit there were 30 patients on the ward. We were advised that there were no patients placed in other wards outwith NHS Fife and additionally, no admissions had occurred into ward 2 from other NHS boards.

We last visited this ward on the 12 December 2017 and made recommendations in relation to auditing of drug prescription cards, a review of psychological and occupational therapy services and the physical environment. An action plan in relation to these was sent to us outlining work being undertaken in these areas. On this visit we wanted to meet with patients, follow up on these recommendations, and look at the quality of care and treatment, engagement with patients and care planning.

Who we met with

We met with and/or reviewed the care and treatment of seven patients and also spoke to one carer.

We spoke with the clinical services manager, lead nurse, deputy charge nurse, and two members of the nursing team who were allocated to assist us during the course of the visit. We did not manage to speak to other professionals in detail, but were introduced to an occupational therapist (OT), a consultant psychiatrist, and the pharmacist. We were advised that a peer support worker also covers the ward, unfortunately she was not available on the day of our visit.

Nursing staff advised us that the ward will be going through a period of change in terms of staffing over the next few months, with senior staff members retiring and new staff members joining the team. They remained positive about this, however recognise that this could be unsettling.

Commission visitors

Paula John, Social Work Officer

Moira Healey Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Most of the patients we spoke to were positive about their care and treatment on the ward, and felt that they could approach nursing staff, in particular, to support them. Only one patient commented that they were unhappy at being in hospital and we were able to ensure that their rights were explained to them. Patients stated that they felt

that they could speak to staff on a one-to-one basis, and where this was not possible, (if staff were busy for example) it would be followed up promptly. Contact with medical staff appeared to be happening on a weekly basis for all patients and again, patients were positive overall in this regard. Some comments were made about changes of doctors happening frequently and a lack of continuity of care. Managers had advised us on the day that there had been a series of locum consultant psychiatry appointments during last year. This has now been resolved and NHS Fife has been able to recruit new staff to a number of posts. There was one locum post out of five doctors on the day of our visit.

We were advised that despite the high number of ward rounds, this was not a major issue for staff to manage. All of the consultant psychiatrists also have outpatient clinic work in addition to managing inpatients.

We also spoke to one family member who advised us that he felt that the support of the staff team at the ward was very good and that this had been forthcoming when his relative was both an inpatient and living at home. Patients added that they were involved in aspects of their care planning, and most of those that we interviewed were able to narrate aspects of future planning and decision making to us. This did seem to depend on the individual clinician, however, as some were less well informed. Ward meetings were recorded and there was evidence of participation. It was also apparent that a multi-disciplinary team approach is adopted to care and treatment with nursing, OT and social work services being represented. There was limited psychology input but this is available by referral to a community-based team. There is no dedicated input to the inpatient team. We were told by staff that there is a waiting list for this service.

Nursing staff advised us that the role of the peer support worker has also been important and aided engagement with patients.

We looked at care plans which, as is the case across mental health in patient services in Fife, have a series of standardised forms. These include care plans in relation to observation practice, risk assessments, the passport to health and physical health care assessment tools. We found inconsistent practice in relation to completion of these documents. Some had a lack of detail, while others omitted relevant aspects of a patient's care, an example of which was a patient who experienced issues with self-harm but had no accompanying care plan. Some were not completed fully, not signed, and had no evidence of regular review.

We did, however, find the 'My Safety Plan' and 'Who Am I?' forms - which patients are encouraged to complete - helpful, informative and indicative of good practice. There was some evidence of nursing one-to-one sessions taking place and the majority of qualitative detail in relation to such interventions was contained in the progress notes. We were aware that a care plan audit was happening in relation to one-to-one interventions, but again this appeared inconsistent, and it was not clear how the outcomes of this audit were being applied to practice.

While we recognise that nursing and other multidisciplinary interventions are taking place, we feel that this work is not being accurately reflected in care plans.

Recommendation 1:

Managers should review and regularly audit the current care plans to ensure that they reflect the ongoing care and treatment being provided.

Use of mental health and incapacity legislation

There were eight patients detained under the Mental Health (Care and Treatment) (Scotland) 2003 ('The Mental Health Act') on the ward, on the day of our visit. We were able to locate the appropriate Mental Health Act paperwork which is contained in hard copy case files on the ward. These were completed well and easy to locate.

There were no issues with the paperwork relating to the giving of medication, and all were up to date, signed and appropriately authorised. Where required, certificates authorising treatment where individuals were thought not to have capacity were also in place.

Rights and restrictions

Ward 2 has a secure entry system and there is a locked door policy to reflect this. Patients are able to come and go freely, unless particular restrictions are in place. These restrictions are individually assessed by the clinical team and all patients had a care plan relating to this. There was also evidence that for those detained under the Mental Health Act, that the named person status and advance statements had been discussed with them. This information was clearly recorded in the notes in a 'Mental Health Best Practice' form. Through discussion, it was clear that only some patients and relatives had an understanding of both of these concepts. We were aware however, that advocacy services are accessible and play a role in supporting patients with their rights.

We noted that one patient was subject to specified persons regulations under the Mental Health Act. These give ward staff the authority to restrict specific items such as phones, or limit correspondence. A rationale for this must be clearly documented and details of a review discussed with patients. We were able to identify a reasoned opinion and details of review within the notes, but no specific paperwork. We were able to address this issue on the day of the visit.

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/rights-in-mind/

Activity and occupation

On our last visit, we noted that there were limited activities taking place and patients had told us that there was little to do. There was also limited involvement from the OT service at this time. Psycho-social interventions and psychology input were also limited. Since then we have been advised that there has been discussion with the OT service and they have more of a presence on the ward both in terms of assessment and therapeutic activity. Patients spoke of involvement in arts and crafts groups, music groups and relaxation and exercise. These were run by the nursing team.

There was some evidence of this in care plans but, again, information on activity was found primarily in the progress notes. We did not see an activity planner in any public areas which would have aided patients in highlighting what was taking place on the ward.

We gather that the areas of activity and therapeutic approaches is a work in progress that managers wish to build on in forthcoming months. They are also keen to employ full-time activity coordinators in the future to aid in recovery focused care and treatment. Presently, this activity role will be designated to a member of the nursing team on a daily basis, but this can become compromised if there are staff shortages.

We welcome this move to improvements and will keep this under review during future visits.

The physical environment

As mentioned in our last report, the physical environment is in need of refurbishment. It is situated in the older building of the general hospital and has had some redecoration in recent months but continues to look dated. This was not raised by patients we spoke to on the day, but staff advised that a lack of meeting and quiet space was a problem and that the current staff room was inadequate.

We noted that in both shower rooms off the dormitories that the flooring required immediate attention. One was not draining away water, with the result that this regularly flooded the ward area. The other shower floor was collecting water causing movement underfoot. Nursing staff advised that these issues had been reported but they were still awaiting action. We raised this with managers on the day who will address this matter urgently.

There had been some attempts to improve the communal areas and we noted that the recovery focused artwork has developed on the walls. Some areas however, remained clinical, for example the bathroom, which we were told is used regularly as a means of relaxation.

We are also aware that work has taken place in all areas of the ward to ensure patient safety.

Recommendation 2:

Managers should ensure action is taken to address the shower rooms and ensure maintenance requests are dealt with efficiently.

Summary of recommendations

Managers should review and regularly audit the current care plans to ensure that they reflect the ongoing care and treatment being provided.

Managers should ensure action is taken to address the shower rooms and ensure maintenance requests are dealt with efficiently.

Good Practice

Nursing staff told us that they have been adopting the 'Safe Wards' model over a period of time and that this has improved practice for the team and patients. They were able to evidence some of the work that had taken place and we were able to see this. In particular, staff had worked on roles and boundaries between patients and staff, discharge and recovery and overall safety. They feel that this has reduced the requirement for constant observations.

In line with this, the new guidance published in January 2019 by Healthcare Improvement Scotland, 'From observation to intervention' is also being considered by NHS Fife, but this work has yet to impact on Ward 2. A link to this document can be found here:

https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention/

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

ALISON THOMSON
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 MWC 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

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk