Mental Welfare Commission for Scotland

Report on announced visit to:
Queen Margaret Hospital, Ward 4, Whitefield Road, Dunfermline, KY12 0SU

Date of visit: 23 January 2025

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 the visit there were 14 individuals. Those admitted to Ward 4 typically had a diagnosis of dementia and related conditions.

Ward 4 is considered as 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 informed by the clinical team that those admitted to Ward 4 have complex needs both in relation to their mental health and physical wellbeing and require a high level of support from nursing and allied health professionals (AHPs).

We last visited the service in November 2023 and made a recommendation in relation to Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), specifically for staff to ensure that where a section 47 certificate was in place, all welfare guardians/ powers of attorney had been consulted and their opinion or agreement was recorded. Ward 4 clinical staff extended their compliance with the AWI Act by undertaking audits and additional training to ensure all staff were knowledgeable about their responsibilities with this legal framework.

Who we met with

We met with four individuals and had the opportunity to review five care records. We also had the opportunity to speak with one relative about their experiences of Ward 4.

We met with and listened to the views of the ward-based team on the day of our visit, including AHPs.

Prior to our visit we met with the senior charge nurse and service manager; we also maintained contact with the senior leadership team throughout the year.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work 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 found nursing staff to be “lovely, take time to chat”. We also heard from another individual that they had found their care to be “excellent, second to none, and all staff have been exceptional”.

We had an opportunity to hear the views of a relative who was positive about their relative’s care and the support they had received. We were told relatives felt confident with the care and treatment they had observed, and staff had taken time to listen to them in order to really get to know their relative. Feeling involved in their relative’s care was important and staff had made every effort to ensure where possible, this was achieved.

We also had an opportunity to meet with several members of the ward-based team and AHPs who provided input into the ward. Staff were keen to tell us that they felt supported by the senior leadership team. They were encouraged to attend learning opportunities to promote person-centred care and treatment.

The senior leadership team were positive role models and while there were many competing demands of a busy ward, the senior nursing staff set a confident tone which was acknowledged by staff, individuals and their relatives.

Care, treatment, support, and participation

During our last visit to Ward 4, we found care and treatment that was bespoke and personalised. We were pleased to find that on this visit, care and treatment had continued to be person-centred, with the multidisciplinary team (MDT) taking an active role with all individuals in Ward 4.

We were told the ward-based team were keen to include relatives in terms of collating information about individuals as this would influence care and treatment. There was a recognition that individuals may not always be able to discuss how they would like to receive care, in part due to the decline in their cognitive function. Therefore, it was important relatives were included in care, treatment and plans for the future. Taking time to listen to relatives was seen as an essential part of staff’s understanding of the individual in their care.

We were pleased to find risk assessments that directly influenced care plans, with all assessments having a holistic approach that considered an individual’s complex needs, along with interventions that were required to meet the identified 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 were pleased to see evidence of how staff had

invited individuals and their relatives to discuss what was important to them and how the MDT could support decisions and their views.

Care records
Clinical information was held on 'Morse', an electronic record keeping system. We found care records easy to navigate and noted that there was inclusion of all disciplines inputting information. We were able to see which member of the team was delivering specific interventions and the outcomes of these.

We reviewed several care plans and were pleased to find the standard of record keeping in this area had remained of a good standard. Care plans for people who presented with stress and distress were excellent, with attention to detail evident.

There continued to be evidence of a clinical team who had maintained a psychological model of assessment that considered an individual's former life, pre-diagnosis and how the MDT could provide support to reduce potential 'triggers' that may cause stress and distress.

We were again pleased to see there continued to be a focus upon everyone's physical well-being. We were told by the team this was essential to identify discomfort or underlying physical problems that could often be the consequence of a stress and distress presentation.

Furthermore, we saw improvements in the daily continuation notes that reflected an individual's presentation throughout the day. We found a richer, descriptive narrative that allowed the reader to appreciate how an individual had enjoyed engagement with the ward-based team, their emotional and physical well-being and where the individual presented with stress, how staff had supported them to reach a position of relaxation again.

Multidisciplinary team (MDT)
Care and treatment was provided by an MDT, which included medical and nursing staff, occupational therapy assistant, speech and language therapy, physiotherapy and there was input from older adults community mental health teams.

Other disciplines providing input to Ward 4 alongside the nursing team, were a consultant psychiatrist, psychology, and music psychotherapy. Referrals to other AHPs, including occupational therapy, dietician and podiatry could be made, with referrals accepted without issue. We were told by the ward-based team that psychology has continued to have a recognisable positive impact upon individuals' care and treatment. With psychological formulations now embedded into the ward's ethos, staff had become accustomed to working with a psychological framework.

Clinical staff understood that an awareness of physical well-being and comfort was essential, as pain and discomfort are often the cause for stress and distress

behaviours. The clinical team have taken a robust approach to investigating the physical well-being of individuals. This included ongoing assessment, speaking with relatives and timely referrals to AHPs, including physiotherapy to undertake assessments of mobility that could help reduce the risk of falls. Care plans were influenced by AHPs' assessments and discussed during the MDT meeting.

The MDT met weekly to review individuals' presentation, progress and any interventions required to ensure care and treatment met their needs. We reviewed several MDT meeting notes. Although we were pleased to find a consistent approach with the recording of details from the meetings, we would have liked to have seen evidence a richer narrative of the discussions held in the meeting, as there was limited information documented in the MDT meeting record. We discussed this with the senior leadership team at the time of the visit who advised us that they would audit MDT meeting reviews and make improvements to ensure all information was captured in the MDT meeting framework.

Last year, with the introduction of a service-based social worker and, more recently with another appointment of a social worker, we were told their roles were having a positive impact, particularly as these posts were viewed as a bridge between the hospital and the community / local authority. We discussed with the ward-based team the value of having social workers inputting information onto Morse. By providing 'real-time' updates, this would enable everyone involved in an individual's care and treatment with regular updates, particularly in relation to discharge planning.

There were six individuals who had been identified as delayed discharge from hospital-based care. There were specific reasons for those delays, typically in relation to arranging suitable nursing homes and awaiting welfare guardianship appointments. The ward-based team were supported by a discharge co-ordinator; again, this role was valued as supporting communication between services, including nursing homes, which had greatly improved the links between the services.

There were close links between the ward-based and community mental health teams. With the introduction of link nurses and weekly meetings, there was a recognised improvement with individuals' pathways into hospital and transfer to community placements or services.

Use of mental health and incapacity legislation

On the day of the visit, nine people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

All documentation relating to the Mental Health Act was in place and easily located in individuals' care records.

Part 16 of the Mental Health Act sets out conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were, on the whole, in place for most patients. We identified two treatments that had been added to two people's prescription chart without the required legal authority in place. We brought this to the attention of senior medical staff on the day of the visit as the two individuals we had identified the unauthorised treatment for had recently transferred from other inpatient units where the T3 certificates were already in place.

Senior medical staff on the day of the visit accepted guidance from Commission visiting team and advised us that they would request a second opinion designated medical practitioner (DMP) visit to be carried out, to review the proposed treatment plan.

Recommendation 1:
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.

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 (the AWI 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. On the day of the visit, we found all section 47 certificates to be completed, with detailed accompanying treatment plans in place.

For those people that were subject to AWI Act legislation, we found paperwork relating to welfare guardianship was in place and easily located. Staff were familiar with the legal framework and understood their responsibilities to ensure welfare guardians were consulted in respect of the powers granted in individuals' orders.

For individuals who had covert medication in place, all appropriate documentation was in order, and all had recorded the reviews or documented the pathway where covert medication was considered appropriate. The Commission has produced good practice guidance on the use of covert medication.[1]

The Scottish Government produced a revised policy on do not attempt cardio-pulmonary resuscitation (DNACPR) in 2016. 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

[1] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

not to 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 close family, as well as to note what steps need to be taken to establish the wishes of the individual. In all case, this involvement or consultation should be recorded.

DNACPR forms were completed, with evidence of discussion with nearest relative or proxy, as appropriate. We found hospital anticipatory care plans in place for everyone who had a DNACPR certificate.

Rights and restrictions

Ward 4 continues to operate a locked door, commensurate with the level of risk identified with those in the ward. There was a locked door policy in place and information notices available for visitors at the door to the ward.

When we are reviewing individuals' care records, we look for advance statements. The term 'advance statement refers to written statements under sections 275 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 advance statement. Nevertheless, to ensure individuals were supported to participate in decisions, clinical teams should be able to evidence how they have made efforts to support individuals to do this and that the rights of each person are safeguarded. We saw evidence of these discussions with relatives and welfare proxies throughout the care records.

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

On the day of the visit there were several individuals who required higher levels of support and observation from nursing staff. Each individual had an additional daily assessment to determine whether a higher level of observation was needed. The clinical team acknowledged it is essential for daily reviews to ensure proportionality, in terms of observation, as they were aware that for some individuals, this level of observation could feel overly restrictive or intrusive.

The Commission has developed *Rights in Mind.*[2] 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.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We observed a ward that recognised the value of activities and therapeutic engagement in forming part of their daily commitment to the people in their care. Activities were very much at the forefront of care and treatment; the team understood that when individuals had opportunities to engage with each other and staff, their emotional and physical well-being improved.

We spoke to the activities co-ordinator who was committed to working alongside individuals admitted to Ward 4. While there was a programme of activities available, it was acknowledged that the structure of the programme had to have flexibility built into it. The reasons for this flexibility were, in part, due to the changing presentations of individuals in the ward. We were told there were days where a truly individualised and bespoke activity session was essential, with individuals engaging in therapeutic activities there were not determined by a rigid programme but, one that met the individual's needs on the day.

The ward-based team also acknowledged there were limited opportunities for individuals to visit their communities and had invited the community into the ward, to spend time with people; this had been hugely welcomed by everyone.

A recent collaboration between the ward and a local primary school has been viewed as a great success. Local children spending time engaging in activities with older adults, sharing book reading, crafts, and singing. This had given the children a real sense of understanding of dementia and for individuals admitted to Ward 4, having young people in the ward had provided an opportunity to maintain local community connections. On the day of the visit to Ward 4 we were able to observe the local children reading poems to individuals, sharing stories and playing board games. Everyone looked very happy and content in each other's company.

The physical environment

Ward 4 is based on the first floor of Queen Margaret Hospital. There were a mix of single en-suite bedrooms and dormitory style bedrooms. The ward had gone through a considerable re-fresh over the past 18 months with room updates throughout.

Bathroom facilities had also been updated and new equipment purchased. While the ward did not have access to outdoor space, the team had invested in the environment to ensure individuals, and their families had space to spend time together. The new café based in the ward offered a bright and welcoming space; there was a menu with drinks and snacks available.

Individuals had also benefitted from the purchase of sensory and therapeutic equipment.

We wish to highlight the attention to detail in relation to the cleanliness of the ward. The housekeeping and domestic staff should be commended for their commitment to ensuring the ward was a well maintained and near spotless environment.

Any other comments

Once again, we wish to acknowledge the continuing commitment the leadership and ward-based team have made to promote and deliver person-centred care.

We heard from individuals receiving care that their views were sought; equally for their relatives, this was important to them too. A sense of equal partners in care and treatment was a theme throughout our visit to Ward 4. Nursing staff felt valued by the leadership team, training opportunities to increase knowledge and skills were encouraged therefore, care was provided by a team who were keen to ensure best practice in their chosen speciality.

Summary of recommendations

Recommendation 1:
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.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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 an individual's care, treatment, and support are 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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