

Mental Welfare Commission for Scotland

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

Date of visit: 12 December 2017

Where we visited

Ward 2 at Queen Margaret Hospital is an acute admission psychiatric unit. It is based in a general hospital in Dunfermline and is a 30 bedded facility. It covers a large catchment area of West Fife and is supported by five consultant psychiatrists. It is a mixed sex ward and comprises of two male dormitory areas, two female dormitory areas and six side rooms. We last visited this service on 25 May 2016 and made recommendations relating to prescription records and the physical environment.

On the day of this visit, we wanted to follow up on the previous recommendations and also look at general areas of care and treatment, ensure rights were being respected and review care planning. These were key findings detailed in our last adult acute national themed visit report which was published in April 2017.

Who we met with

We met with and/or, reviewed the care and treatment of six patients, and we met with one carer.

We spoke with the lead nurse for acute inpatient services, the senior charge nurse (SCN) and a number of nursing staff on the ward. We were also able to review the medication of all patients on the ward. There were 25 in patients on the day of our visit.

Commission visitors

Paula John, Social Work Officer

Claire Lamza, Nursing Officer

Peter Rennie, Medical Officer

What people told us and what we found

Care, treatment, support and participation

All of the patients we spoke to were positive about the care and treatment they were receiving and felt that they could engage with nursing staff. Some made the comment that this was difficult at times as the staff were busy and not always able to speak to them or spend sufficient time with them. In general, patients felt that communication across the ward was good.

We also spoke to one relative who, although actively involved in their relative's care, felt that they struggled to get their views across to some of the nursing staff and the medical staff in particular. They felt at times that these were not taken on board and that some aspects of care and treatment had not been as effective as a consequence. Advice was given in this area and raised with staff on the day.

We looked at care plans which had standardised paperwork and there was an opportunity here for the plans to be personalised to individual needs. However not all of the care plans reflected this, and there was an inconsistency in how they were being completed. For example, outcomes for each patient were not always completed and some risk assessments were not dated or reviewed. We were made aware that an audit of nursing care plans is currently ongoing and these issues will be addressed.

There was evidence of nursing one-to-one sessions taking place with patients, and the multi-disciplinary meetings were documented and outlined care management and discharge planning. The meetings also reflected a range of professionals being present at each meeting. There was less evidence of participation from family members or carers but patients were routinely invited. Given that there are five consultant psychiatrists covering this ward, there are five ward meetings for nursing staff and others to attend. The SCN advised that this can be challenging at times particularly when the ward is busy.

We would like to be updated on the findings of care planning audits and made aware of what changes in practice have occurred as a consequence.

Use of mental health and incapacity legislation

There were a number of patients on the ward detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. We were able to find, within the case notes, copies of the papers authorising detention on the ward. In addition, the doctor within the Commission team spent some time looking at the drug prescription sheet to ensure that legal authorisation was in place. There were seven instances where issues had to be raised with staff, and revisions to paperwork required to be made. Examples included paperwork being out of date, medications being prescribed but not specified on the paperwork and inaccuracies in dosage.

Given the number of medical staff covering this ward, it would be helpful if drug prescription sheets could be regularly audited. We were advised that a pharmacist does visit the ward and has input to the weekly meetings.

We were advised that advocacy services are in place, and they hold a weekly drop-in service and assist patients with claiming their rights under the legislation. A peer support worker is also in place on the ward, but unfortunately was not around on the day of our visit.

Recommendation 1:

Managers should introduce a system to ensure that regular audit of drug prescription sheets for detained patients is in place.

Rights and restrictions

The ward has a secure entry system, and a locked door policy is in place. Patients are able to come and go freely, however, if any restrictions in terms of access are required then this is included in an individual's care plan.

We found that some patients were aware of their rights in relation to this, but not all, and we were able to offer advice in this area. More information on patient rights can be found on our website via this link: <http://www.mwscot.org.uk/rights-in-mind/>

There were no issues with suspension certificates, which authorise periods of time out with the ward setting for detained patients.

Where patients were subject to specified person's regulations, i.e. where they were restricted in terms of access to correspondence and telephones in relation to risk, the appropriate paperwork was located in files. Reasoned opinions were also recorded.

Activity and occupation

There were a number of activities taking place on the ward and nursing staff were involved in these. We saw evidence of this in care plans. Despite this, some patients informed us that they had little to do on the ward and would appreciate additional activities or therapeutic occupation. In addition, patients felt that staff were sometimes too busy with other duties and did not always have time for targeted activity.

The SCN advised that the involvement of occupational therapy and psychological services are currently limited with no direct sessions being delivered. These services however, are available by referral. We were advised by the lead nurse that the issue of structured therapies and activities is being reviewed and considered with the aim of improvement for patients. We would hope to see the benefits of this work on our next visit.

Recommendation 2:

Hospital managers should review the provision of psychological and occupational therapy services to the ward and update the Commission in three months.

The physical environment

The physical environment of the ward has been commented on previously by the Commission and we did note some improvements in terms of redecoration, walls painted and new flooring. Staff had also involved patients in completing artwork and recovery focused materials on the walls which were colourful and positive in content. However, there are still a number of issues with the environment itself and some of these are not easily addressed given the design of the building. Examples here include toilets situated in the dining area, limited availability of quiet and private spaces and large dormitories which limit privacy.

Recommendation 3:

Hospital managers should review the physical environment and make changes accordingly.

Summary of recommendations

1. Managers should introduce a system to ensure that regular audit of drug prescription sheets for detained patients is in place.
2. Hospital managers should review the physical environment and make changes accordingly.
3. Hospital managers should review the provision of psychological services and occupational therapy to the ward and provide an update in 3 months.

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.

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