Mental Welfare Commission for Scotland

Report on announced visit to:
Ward 1, Queen Margaret Hospital, Whitefield Road, Dunfermline, KY12 0SU

Date of visit: 14 November 2024

Where we visited

Ward 1 is an 18-bedded, mixed-sex ward based in Queen Margaret Hospital. The ward provides assessment and treatment for older adults who have a diagnosis of dementia, including organic-related illnesses. The ward also admits individuals with functional illness, including depression and psychosis.

On the day of the visit, there 14 individuals receiving care and treatment on the ward.

We last visited the ward in September 2023 and made no recommendations at that time. We have maintained contact with the service as we were informed there would be further progress with the ward environment, and the ward-based team were keen to continue with initiatives to improve individuals' experiences of care and treatment in Ward 1.

Who we met with

We met with six individuals in person and reviewed the care notes of four individuals. We also had the opportunity to meet with two relatives, several staff, including the ward-based nursing team, the psychologist, the senior medical staff, the music psychotherapist and a student nurse on placement in Ward 1.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

Kathleen Liddell, social work officer

What people told us and what we found

The over-arching theme from everyone we spoke to and met with was how much they valued the care and treatment provided in Ward 1.

People we spoke to described the nursing team as “very caring” and told us that “nurses are always available; I feel safe here.” Relatives told us “communication with the staff is excellent, I can phone any time of the day and whoever I speak to knows about my relative, how their day has been and in detail too.”

For staff working in Ward 1, they told us “we have a team culture; everyone has a voice and we make sure we support people in our care, their relatives and each other.” We were also informed by relatives that “difficult conversations are managed with compassion and sensitivity”, particularly in relation to palliative care.

Relatives told us they had felt welcomed into the ward by the clinical team and flexible visiting arrangements were promoted to ensure relatives were given opportunities to visit the ward throughout the day. Relatives had mentioned they would find having a Ward 1 welcome pack helpful, particularly for the early days of an admission to hospital and what to expect. We brought this to the attention of the leadership team and were told that there is an information pack is currently in draft form with the intention to share this with relatives soon. We look forward to seeing this on our next visit.

Care, treatment, support, and participation

On the day of the visit to Ward 1 we were pleased to find a multidisciplinary team (MDT) who had continued to maintain a focus upon person-centred care and treatment. With an emphasis on a psychological and physical well-being of every individual, we found evidence of a treatment model that was holistic and personalised.

Individuals who were admitted to Ward 1 required robust psychological and physical assessments with individual care planning thereafter. We were told that often individuals had been cared for at home with relatives providing support and care. The ward-based team endeavoured to work alongside relatives and viewed their commitment to continue to provide support during their relative’s admission as important.

We saw treatment plans that evidenced where relatives’ views had been gathered and provided essential information for personalised care planning. During the early days of admission to Ward 1, each individual was assessed in relation to their physical health and mental well-being. There was a multidisciplinary team (MDT) approach to assessments, meaning that individuals had a range of nursing, medical and allied health professionals’ assessments. Each of the disciplines shared their assessment evaluations that provided the basis of care planning and treatment.

The ward-based team valued the input from psychology, as this input had meant individuals who presented with stress and distress each had a psychological formulation to ensure the team were able to support people by understanding potential triggers, thus reducing anxiety. The psychological model of care and treatment had become embedded in the ward's philosophy and was welcomed by staff, individuals and their relatives.

Where individuals had difficulty engaging in the process of devising their own care plans, we saw evidence of how the nursing team had supported people with some decision-making to ensure there was a shared opportunity for person-centred care.

Care records

Individuals' information was held on the electronic system, Morse. We found care records easy to navigate and included all disciplines who inputted information. We were able to see which member of the team was delivering specific interventions, outcomes, and progress.

We would like to have seen more detailed narrative in the daily progress notes. We were able to see where specific interventions had been identified through assessments and care planning, however we were unable to find a consistent approach to the recording of this in individuals daily electronic records. We brought this to the attention of the senior ward-based leadership team on the day of the visit.

Individuals' care records held essential information, including a range of assessments that included a focus upon physical and emotional well-being. There was a clear focus upon physical well-being and we were told nursing staff recognised the importance of physical health impacting upon emotional well-being.

Regular assessments were undertaken to identify discomfort or underlying physical problems that could of be the consequence for stress and distress. Where there were issues identified, the ward-based team made timely referrals to allied health professionals (AHPs) to ensure any problems were quickly resolved. We could see during our reviews of care records there was regular input from AHPs including occupational therapy, speech and language therapy, dietician and physiotherapy. Bespoke care plans were in place to support individuals, and these were reviewed regularly by AHPs.

We were keen to review care plans, as we noted during our last visit that there had been improvements and want to be assured that this had been maintained. We were pleased to find care plans were consistently person-centred and personalised. Nursing staff took the lead with developing and reviewing care plans however, the views of relatives and the MDT were incorporated to ensure essential information was included that supported the need for specific interventions.

Multidisciplinary team (MDT)

There were a range of disciplines providing input in Ward 1, including nursing, consultant psychiatrist, medical staff, psychology, music psychotherapy. In addition, there were regular visits from AHPs.

The ward-based team recognised the importance of a holistic model of care and treatment, which was promoted throughout the documentation we reviewed and evident from speaking with several members of the ward-based team and wider MDT. We were told during our last visit to Ward 1 that staff were keen to promote a psychological formulation approach; they recognised that stress and distress experienced by individuals frequently came from a sense of fearfulness and anxiety. We were pleased to hear this approach to understanding individuals through a psychological lens had been promoted throughout all assessments, care and treatment. Furthermore, the ward-based team had regular reflective practice sessions to support their own well-being too. The nursing team told us that additional training opportunities throughout the past year had increased their confidence, knowledge and skills.

The MDT met weekly to discuss individuals' presentation, progress and any interventions required to ensure care and treatment met the needs of individuals admitted to Ward 1. We reviewed several MDT meeting notes and were pleased to find a consistent approach in recording details from the meetings.

We were able to see evidence of regular reviews from AHPs, assessment outcomes and any actions required.

With the introduction of a recently appointed service-based social worker, we were told their role was already having a positive impact, particularly as it was viewed as a bridge between the hospital and the community/local authority.

There were four 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 communication between services, including nursing homes, had greatly improved.

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 individual pathways into hospital and transfer to community placements or services.

Use of mental health and incapacity legislation

On the day of our visit to Ward 1 there were eight individuals who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). There was evidence that nursing staff had made efforts to support those individuals with their understanding of their rights in relation to the Mental Health Act, however, for some people who presented with a significant impairment of their cognitive functioning, understanding of their rights and restrictions would have been difficult to communicate or understand.

Part 16 of the Mental Health Act sets out conditions under which treatment may be given to detained individuals, who are capable or incapable of consenting to specific treatments. On the day of the visit, we found certificates authorising treatment (T3) under the Mental Health Act were in place, where required, and corresponded to the medication being prescribed.

Where an individual lacks capacity in relation to decisions about medical treatment a certificate 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 completed, with detailed treatment plans in place.

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

Rights and restrictions

Ward 1 continued to operate a locked door, commensurate with the level of risk identified with the patient population. A locked door policy was in place.

When we review individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under section 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 responsibly for promoting advance statements. The majority of individuals in Ward 1 would be unable to write their own advance statement.

Nevertheless, to ensure individuals are supported to participate in decisions, nurses should be able to evidence how they have made efforts to enable people to do this

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

and that the rights of each individual are safeguarded. We raised this with managers on the day.

There was an advocacy service available to support individuals and their relatives. Nursing staff could initiate referrals on behalf of individuals admitted to Ward 1. Advocacy attended the ward regularly and could support individuals in relation to Mental Health Tribunal for Scotland hearings and this support could be extended to carers if required.

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.

Activity and occupation

With members of the MDT investing time and effort to improve the psychological well-being of individuals admitted to Ward 1, we heard this had continued to improve the overall experience for people and their relatives.

Activity and occupation were deemed to be essential for developing therapeutic relationships. With the advantage of having a dedicated activities co-ordinator we observed individuals enthusiastically engaging in activities and socialising with their peers.

Having opportunities to engage in music psychotherapy was highly regarded and offered therapeutic engagement within the ward environment. The ward-based team recognised having a programme of activities available for individuals was an investment to maintain life skills while also having time to relax in the company of staff.

The physical environment

Over the last year we had received regular updates from the senior leadership team, as we were keen to hear of the continuing improvements to the ward. We were pleased to find a ward that was welcoming, bright and well-maintained.

There had been attention to detail in relation to providing a 'dementia friendly' environment with the addition of a 'serenity café' for individuals and their relatives to enjoy during visits. The ward had a mix of dormitory style bedrooms and single en-suite bedrooms. Relatives told us they were not always sure where they could visit their family member, as entering the dormitories had not felt appropriate. The ward-based team recognised the ward was not afforded many communal or private spaces, however there had been some changes to the environment that meant an additional private room had been made available for visitors.

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

Any other comments

We wish to acknowledge the continued effort and determination the ward-based team and allied health professionals had made to promote a model of care that kept all individuals at the centre of treatment decisions. Person-centred care can be compromised when services have many competing demands. It was clear the senior leadership team had invested in their staff to ensure they were confident and supported to deliver care and treatment that met the identified needs of people admitted to Ward 1.

Summary of recommendations

The Commission made no recommendations; therefore, no response is required. However, we would 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. We will contact the service in three months' time to gather feedback about this.

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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