Mental Welfare Commission for Scotland

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

Date of visit: 7 November 2024

Where we visited

Ward 2 is an adult admission ward, based in Queen Margaret Hospital, a general hospital in Dunfermline. The ward can accommodate 30 adults; on the day of the visit there were 26 people receiving care and treatment.

The ward is a mix-sex environment with a dormitory style bedrooms and six single rooms with en-suite facilities. The dormitories have six beds in each, with little room for storage. During this visit we wanted to meet with people receiving care and treatment in Ward 2 and to review their care.

We also wanted to follow up on the previous seven recommendations which included issues around rights and restrictions, consent to authorising treatment, evidencing one-to-one sessions between individuals and nursing staff. We also made recommendations that included activity provision for individuals and promotion of therapeutic and recreational engagement. Lastly, we were concerned about Ward 2's environment. There were several areas that required upgrading and maintenance.

We received a detailed action plan and updates from the senior leadership team over the past year.

Who we met with

We met with 12 people and reviewed the care records of six. We also had the opportunity to speak with two relatives.

We spoke with the service manager, lead nurse, the senior charge nurse, charge nurse, consultant psychiatrist.

We also had the opportunity to meet with an occupational therapist, a student nurse on placement in Ward 2, social worker and staff from Voiceability Scotland, an advocacy service providing regular input into the ward.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Sandra Rae, social work officer

What people told us and what we found

We met with and spoke to individuals who had been admitted to the ward recently or had been receiving care and treatment for many months. Typically, we heard that staff were helpful, some were described as “excellent”.

However, we also heard that staff were very busy, and time spent with individuals was not as frequent as they would wish or had expected during their admission to Ward 2.

We heard nursing staff attempted to undertake recreational activities however, while there was a scheduled timetable available, this was not as predictable as individuals would like. We heard positive feedback about the opportunities to engage with arts psychotherapy, life skills group and the positive impact of having a consultant psychiatrist who took time to listen to individuals. This positive aspect of care was raised with the visiting team on several occasions; having senior doctors who met regularly with individuals and their families to listen and work in collaboration was valued and helped with recovery.

There was a recognition that the ward-based nursing team attempted to support individuals however, this was hampered by too few resources, and this was a source of frustration for everyone we spoke to.

We also heard that the dormitory accommodation offered very little privacy and comfort for people. When we last visited Ward 2, we were told the dormitory style bedrooms were not acceptable and often increased individuals’ levels of anxiety. Unfortunately, we heard similar views on this visit.

Care, treatment, support, and participation

When we met with individuals receiving care and treatment in Ward 2, we asked whether they had felt involved in their admission to hospital.

We asked whether there were meetings with staff to discuss specific goals to aid recovery, which member of the ward-based team would be supporting the individual and whether individuals had been able to participate in the care plans. The feedback we received was mixed. For some people they felt very included in their admission pathway, their views were sought, and goals were agreed. For others, participation seemed limited, people were unable to tell us about their specific goals for the admission to hospital or which members of the ward-based team were providing input.

Where we were able to identify person-centred care planning, there was good evidence of participation from the individual and their relatives. These care plans were detailed, reviews recorded and where necessary plans were updated or amended. We would have liked to have seen a consistent approach to inviting

individuals to participate in their care, inviting people to be equal partners in their recovery journey would likely improve engagement and support recovery.

Recommendation 1:
Managers should carry out an audit of care plans to ensure they fully reflect an individual's 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[1]. 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.

Care records
Information on individuals' care and treatment was held on the 'MORSE' electronic record system. We found individuals' care records relatively easy to navigate.

There was a 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 others that lacked specific details of who would be providing support and the reasons for this. We would like to have understood where risks were identified, the measures 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, had 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.

The introduction of 'canned text' invited nursing staff to consider specific areas of an individual's presentation. There were seven areas of focus including mental state, activity, diet/fluid intake, current risk, physical health, medication, passes, and family and carer contact. While we agreed this was a helpful approach to ensure nursing staff endeavoured to consider a holistic model of care and treatment, we were disappointed with the lack of detail and, at times we found language to describe individuals' presentation to be pejorative and judgemental. This appeared to be out of keeping with the ward ethos as we were told ward-based staff were keen to promote recovery through therapeutic relationships.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Recommendation 2:
Managers should ensure all staff who document in care records are provided with guidance to ensure all documentation is appropriate and professional.

Multidisciplinary team (MDT)
Ward 2 has 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 input from allied health professionals (AHPs) providing support throughout the week. AHPs who provided input included physiotherapy, speech and language therapy and dieticians. All referrals to these services were met promptly with AHPs providing updates to the ward-based team.

Individuals told us they welcomed the sessions with the music psychotherapist. There had previously been opportunities for group psychotherapy however, this was no longer available and was missed. Occupational therapy (OT) was also highly valued, with the recent completion of a life skills course that had been extended beyond the ward; this was a positive development for all individuals who required additional support.

There were five locum consultant psychiatrists, and no substantive medical staff. Although all consultants were locums, several 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. We were told while there were some locum psychiatrists who were frequently present on the ward, this was not always the case for all of them. We brought this to the attention of the senior leadership team, as we recognised having regular opportunities to meet with senior medical staff was essential for individuals, their relatives and the nursing team.

We had access to several MDT reviews which were held in the electronic record system. We were pleased to see those reviews were detailed and provided a clear focus upon individuals' views of their care, any interventions required to support recovery and action plans for individual staff to complete before the next review.

We were keen to meet with the newly appointed social worker who had been in their post for several weeks. This appointment was to act as a bridge between the ward and community services, including the local authority. We were told the post had already had a positive impact for people who required additional services to support their discharge from hospital-based care.

Furthermore, with regular communication between senior staff from the ward and the community mental health team (CMHT) there was now a process in place to ensure referrals from the ward to the CMHT were discussed in good time therefore reducing the risk of delayed discharges.

Use of mental health and incapacity legislation

On the day of our visit, there were 14 individuals in the ward who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Individuals we met with during our visit had a variable understanding of their detained status where they were subject to detention under the Mental Health Act.

We were aware of some people who were receiving their care in hospital informally. They were not necessarily clear 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 clinical team's requirement to ensure all individuals, whether subject to legislation or receiving their care 'informally', understood their rights and any restrictions placed upon them and the reasoning for this.

Recommendation 3:
Managers should ensure all individuals admitted to Ward 2 are made aware of their rights, whether they are subject to Mental Health Act legislation or are receiving their care and treatment informally.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. 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.

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 a patient had nominated a named person, we found the relevant documentation in their care records.

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 certificate. Where an individual required fundamental healthcare, this was authorised by a completed section 47 certificate, with an accompanying treatment plan.

We heard about two recent separate incidents which had led to the completion of adult concern referrals under Adult Support and Protection (Scotland) Act, 2007 (Adult Support and Protection Act). There was a lack of clarity as to the outcome of the concerns at the time of this visit. We enquired whether the ward-based team had

received any updates from the local authority, specifically from the ASP team. The senior leadership team was not aware of any updates. This was concerning as there appeared to be an absence of a local procedure and protocol to enable staff to work within the Adult Support and Protection Act framework.

Recommendation 4:
Managers should ensure all staff working in Ward 2 are knowledgeable about Adult Support and Protection (Scotland) Act 2007 and follow local protocols to promote safeguarding.

We found a completed 'do not attempt cardiopulmonary resuscitation' (DNACPR) form for an individual whose care we reviewed. This DNACPR form had been completed before the person transferred to Ward 2 and it was not clear whether the proxy decision maker had been consulted in relation to the decision. We were also unable to locate a hospital anticipatory care plan (HACP) that would direct staff to ensure the individual was supported appropriately should their health deteriorate. We discussed this with senior nursing staff and the consultant psychiatrist on the day of the visit as it is necessary for each individual who has a DNACPR form in place to have a detailed HACP held within their care records.

Recommendation 5:
Medical staff should review all DNACPRs on admission to the ward to ensure that these are fully completed and communication with proxy decision makers or relatives is documented.

Rights and restrictions

Ward 2 continues to operate a locked door, commensurate with the level of risk identified in the ward. There was a locked door policy in place and available to all who entered the ward.

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 the paperwork to be in order and reasoned opinions in place.

The Commission has produced good practice guidance on specified persons[2].

When we reviewed individuals' files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

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. We met with staff from the advocacy service who regularly received referrals from Ward 2, support individuals during meetings and attend Mental Health Tribunal for Scotland (MHTS) hearings to ensure individuals are supported throughout their admission to hospital.

The Commission has developed *Rights in Mind.*[3] 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

We were told by several individuals that they had regular input and support from a range of AHPs. Music psychotherapy remained in place however, this was now provided as one-to-one sessions rather in a group setting.

Additional support, assessment and treatment continued to be provided by OT, who had an important role in providing individuals with formal functional assessments along with recreational and therapeutic engagement. We were pleased to hear of a new initiative to bring 'music for life' in Ward 2. Often, music for life is available for adults living with cognitive impairment, such as a diagnosis of dementia. Staff in Ward 2 recognised having a personalised music playlist available for individuals and opportunities to discuss their choices and emotional connections to music had a positive impact in reducing stress and distress. This initiative was in the early stages of delivery to individuals admitted to Ward 2, and we are looking forward to hearing how this progresses over the next year.

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

We were told inpatient services recognised the value and importance of therapeutic engagement however, there had been no progress with recruiting into the activity co-ordinator post so the responsibility for activity provision was allocated to nursing

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

staff. Inevitably, competing daily demands placed upon the existing nursing establishment determined whether scheduled activities took place. This was a source of frustration for individuals admitted to Ward 2 and the ward-based team. We were told by individuals we met with that they enjoyed spending time with staff and recreation often alleviated stress and anxiety.

Recommendation 6:
Managers should consider how to support staff to deliver recreational and therapeutic activity provision in Ward 2.

The physical environment

We were pleased to see there had been some improvements to the ward environment with re-decoration in several rooms and the addition of a relaxation and MDT meeting room.

The ward continues to admit in the region of 28 patients and often reached capacity. This was significant, as it meant individuals continued to sleep in dormitory style accommodation that was neither appropriate for this population or large enough for people to have enough room and space to feel comfortable.

Recommendation 7:
Managers should consider whether having a ward that can accommodate up to 28 individuals is suitable for people who present with significant mental ill-health.

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

The ward had six single bedrooms with en-suite facilities. There were four dormitories that accommodated six individuals per dormitory. With little privacy between beds, a curtain around each bed and, with widows into the main corridor of the ward, we were told this provided individuals with little dignity and increased their levels of stress.

Recommendation 8:
Managers should consider whether having six bed spaces for each dormitory supports individuals' needs for safety, privacy, and dignity.

We heard that the large communal room available for people had been updated and found this to be bright and welcoming, although it was a multi-purpose room used for dining, watching TV, recreation, and visitors. This meant it was not a room people felt they could use to relax. There was one other room available that was used as a relaxation room or for one-to-one meetings between staff and individuals.

We were pleased to see the outdoor space was accessible for everyone. Previously the garden had been used by individuals for cigarette smoking or vaping. It had not been an attractive space and therefore had not been used by many individuals on the ward. On the day of the visit, there was no evidence of cigarette smoking and this in turn had meant the ward did not have a lingering odour of stale cigarettes. People we spoke to had mixed views of not having an outdoor space to smoke however, people were largely in favour of those restrictions, which are now law.

We were told there were likely to be improvements to mental health wards based on the Queen Margaret Hospital site. This will include additional updates to the ward environment and possible moves in the hospital as other wards across the Fife mental health estate also required updating or refurbishment. We have asked the senior leadership team to provide updates with their progress.

Summary of recommendations

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Recommendation 5:
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Service response to recommendations

The Commission requires a response to these recommendations 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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