Mental Welfare Commission for Scotland

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

Date of visit: 24 March 2026

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Ward 2 is a 24-bedded, mixed-sex, adult acute admission ward, based in Queen Margaret Hospital, a general hospital in Dunfermline. On the day of the visit there were 23 people in the ward.

On our last visit, the ward admitted up to 29 people; we were pleased to hear of the reduction in the number of people being admitted to Ward 2. The senior charge nurse (SCN) told us that an agreement had been made with senior managers that the maximum number of people being admitted was capped to 24 people, which included two surge beds.

We last visited this service in November 2024 on an announced visit and made eight recommendations relating to care planning, record keeping, activity provision, individual rights and bed-based numbers. We also made recommendations about 'Do Not Attempt Cardiopulmonary Resuscitation' forms (DNACPR) and the staff team's knowledge base with regards to the Adult Support and Protection (Scotland) Act, 2007 (ASP) legislation.

We received a response from the service that was detailed in an action plan as to how the service planned to meet the recommendations.

On the day of this visit, we wanted to follow up on the previous recommendations and find out about people's experience of being admitted to Ward 2.

In our 2024 report we had made a recommendation about the lack of therapeutic activity provision and were informed on our visits to other wards that there was going to be investment in activity provision across all mental health wards. We wanted to get an update on this and to find out about the range of therapeutic activities that were in place to support people with their recovery in this ward.

Who we met with

We met with 11 individuals and reviewed the care records of five of those people. As this visit was unannounced, we did not meet with any relatives on the day.

We asked the SCN to inform relatives of the visit to encourage anyone to contact the Commission following the visit if they wanted to speak with us.

We spoke with the senior charge nurse (SCN) and other ward-based staff. We also met with senior leaders from NHS Fife at our feedback session.

Commission visitors

Tracey Ferguson, social work officer

Susan Tait, nursing officer

Gordon McNelis, nursing officer

Dr John Crichton, executive director (medical)

Dr Adebola Eromosele Adegbite (ST6 medic)

What people told us and what we found

Throughout the day of the visit, we introduced ourselves and chatted with most of the individuals in the ward.

Individuals were at different stages of their recovery; some individuals had recently been admitted to the ward, others were at the stage of discussing and preparing for discharge where they were spending time off the ward as part of the transition to the community.

Most people's feedback was positive about the staff. They described staff as "good, nice, kind and approachable". One described the staff team as "perfect".

A few people told us that staff were very busy, as was the ward and that at times, the ward could be noisy. A number of people told us about their regular one-to-one meetings with staff and how they found those meetings helpful. Several individuals said that they felt involved in decisions about their care and treatment and met with the doctor regularly.

Most people knew about their rights, and this included people had been admitted to the ward on an informal basis.

One person told us that they felt safe on the ward and how their admission had benefitted them, describing their experience as "positive". Some people were able to tell us about their care plans, however we heard from a few others who has not seen their care plans, nor had they felt involved.

One person described going into the weekly multidisciplinary team (MDT) meeting as "daunting" due to the number of people present but had also been informed that they could ask some people to leave the meeting if they wished to.

We heard less positive feedback around individuals' frustration of being delayed in hospital and a lack of discharge planning. A few people told us about the number of times there had been a change of doctor since their admission and how this was not helpful.

Most people told us that there was a lack of activities and at times it was a long day, often leaving them feeling bored. Some individuals told us that they were happy to share a dormitory, whereas we heard from others that sharing their bedspace led to a lack of privacy. A few people told us that they chose not to sit in the dining room due to the cigarette smoke coming into the dining room from the outside patio.

From speaking to the staff, we got the impression that they knew and took the time to get to know the individuals on the ward well, including those who had recently been admitted. Throughout the visit we saw caring and supportive interactions

between staff and individuals and where situations had to be de-escalated, we saw staff approach this sensitively.

The ward had a designated floor nurse each day and we were told about their role and remit. The SCN informed us about the various audit processes in place to improve standards.

We spoke with staff and heard comments such as: “it’s a good, supportive team”, “I enjoy my work”, “it can be disheartening when I come to the ward and get told I am working in another area for the day; this makes staff feel anxious”.

Staff told us that there were occasions where they sometimes had to be moved to other areas due to clinical activity in these areas, which meant the staffing levels in Ward 2 would often go into ‘amber’, directly impacting on staff being able to deliver some aspects of care, such as one-to-one discussions and activities. We were concerned to hear that the SCN was often be counted in the numbers for the shift, which directly had an impact on the SCN’s ability to perform their duties; we saw this on the day of the visit.

We were told that on each shift there would tend to be three registered nursing staff on the ward with rest of team being health care support workers (HCSWs). The SCN told us that since our last visit there had been efforts made to fill vacant posts across the service. There was now less than two full time Band 5 nursing vacancies, which was an improvement since our previous visit.

We are aware that the Health Board are undertaken work with Healthcare Improvement Scotland to ensure safe staffing levels and that the ward is required to meet the obligations of the Health and Care (Staffing) (Scotland) Act, 2019.The SCN told us that in order to ensure safe staffing levels were in place, there was a staff huddle each morning between senior staff; this was to ensure wards had sufficient staffing to meet the clinical needs and demands in each area.

Care records

Care records were held on the electronic system, MORSE. We found this easy to navigate and were able to access the relevant documents. Documents were stored under specific sections although we were told that it could be difficult to find where documents were stored, as it would depend on where the staff member who started the document had stored it.

On another local visit to a service in Fife, senior managers had informed us that this was being looked at and we will continue to request an update during our local visits.

Care, treatment, support, and participation

The care and treatment on Ward 2 was mainly provided by the nursing team, with some dedicated sessions from occupational therapy (OT).

We found the initial assessments completed by medical and nursing staff to be thorough and comprehensive, with a recorded plan of action regarding the purpose of admission and what it hoped to achieve.

All care records we reviewed had a risk assessment in place and these were mostly detailed with evidence of regular review. We brought one risk assessment to the attention of the SCN and requested this be followed up, as a revised risk assessment had not been completed on admission and the community risk assessment was still in place.

We found one-to-one meetings between individuals and nursing staff were happening regularly and most provided a good account of the discussion and of the individual's views. We found that there were some instances where having regular one-to-one meetings with some individuals was more of a challenge and staff had recorded the reasons why these were not carried out.

We wanted to follow up last year's recommendation around care planning. We found that the care plans were detailed, holistic, and provided comprehensive information regarding the interventions required to meet their outcome. The care plans were being reviewed regularly and most had a good level of detail following their review.

We found that there had been progress around care planning since our last visit, however we noted that an individual's participation varied. We advised that it would be good for staff to build on the progress they had made with care planning and that they should evidence the person's involvement, along with recording their views at the review stage of care planning, as this was lacking.

We felt that there was a missed opportunity in recording the individual one-to-one sessions that took place.

We requested the SCN to follow up on one individual's care plan who had not long been admitted to the ward. We found a detailed safety plan in place, however there were no other care plans present.

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.

Staff recorded daily updates on the individual's progress using a pro forma. This pro forma provided a useful prompt for staff that ensured the records were meaningful and descriptive around an individual's presentation. We saw that most daily entries were detailed but also where the information was less detailed and would have benefitted from more narrative.

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

We found on this visit that there had been improvement in the daily recordings and the new pro forma supported this. We were told that the staff team had a session with the Nursing and Midwifery Council (NMC) in June 2025 and the focus of the sessions was around documentation and record keeping. We heard that of the positive changes developed by the SCN, who had put in place an audit system to make improvements and build on good practice.

We wanted to follow up with regards to our recommendation about DNACPR certificates. There was one DNACPR in place that had been reviewed since our last visit and the information set out in this was in order.

The SCN informed us that staff had undergone ASP training and that the service had developed a new process to ensure there was follow up with referrals and that local processes were being adhered to.

Multidisciplinary team (MDT)
We were told that there were five consultant psychiatrists who provided input into the ward and of those five, some had recently taken up the post on a locum basis.

Each consultant psychiatrist covered a specific geographical area in the community and they were responsible for that person's care and treatment on admission. We were told that the MDT met weekly, with each consultant psychiatrist holding their own separate MDT meeting.

The professionals who attended those meetings mainly consisted of nursing staff and the consultant psychiatrist. There was also regular attendance at those meetings from occupational therapy (OT), pharmacy, community psychiatric nurses (CPNs) and mental health officers (MHOs) when required.

The MDT meeting records were held in MORSE. We found the record of the meeting to be comprehensive, with a summary of the individuals' weekly progress and a good account of the person's ongoing mental and physical health care.

We noted that individuals attended this meeting and their views were incorporated into the MDT record.

The format of the electronic MDT document provided the clinical team with sufficient prompts to ensure specific aspects of the care and treatment were covered. An example of the prompts included treatment forms, medication, legal status and time out of the ward.

Where people wanted their relatives involved, we saw where this was taking place as part of the MDT process and found that discussions were happening between nursing staff and relatives out with the meeting.

In terms of physical health care monitoring, we found that this was carried out by the consultant psychiatrist or the resident doctor. As we would expect to see, there was ongoing monitoring of people's physical healthcare from the point of admission. We saw individuals being supported to continue to access other healthcare interventions, such as an opticians and dentistry while in hospital, and access to other allied healthcare professionals (AHPs) as needed.

The ward had dedicated input from OT and we heard that any referrals were actioned quickly; most referrals were for functional assessments, mainly to support discharge planning. The OT told us that there was limited input in Ward 2 and this was due to vacant posts across the service and that referrals were prioritised across services. We could see evidence of this in the care records, which detailed the purpose of OT involvement and the plan of action around this.

We wanted to find out about the psychology provision and input into the ward. We would have expected that all assessment wards would have timely access to psychology input, but this was not the case. We were told that Ward 2 had no dedicated input from psychology. On the day of the visit, we felt that there were individuals in the ward who would have benefitted from psychology input, which could also have provided support to the nursing staff.

We heard that there had been some exceptional circumstances where psychology had provided input, but this was on a case-by-case basis. We had been informed on a previous visit to another acute ward that a 'situation, background, assessment and recommendation' (SBAR) report had been submitted to the senior executive team regarding having psychology input across adult wards; we will request an update from the senior manager about the progress of this.

Recommendation 1:
Managers must ensure that there is psychology provision available to the individuals in the ward.

With regards to people who were in hospital awaiting discharge, we were told that the clinical services manager and the discharge co-ordinator met fortnightly to discuss discharge pathways for individuals and identify any potential challenges early on in the person's admission, which would enable progress to be made.

We were advised that there were six people in the ward whose discharge was delayed. The SCN told us about the progress that had been made around delayed discharge since our last visit, and it was positive to hear of some of the individual's progress towards discharge on this visit.

We were told that some of the current delays were around community placements, care packages and the legal framework that needed to be in place prior to a discharge.

Use of mental health and incapacity legislation

On the day of the visit, eight people in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to an individual's detention status was easy to locate on the electronic system.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We wanted to find out what action the service had taken with regards to meeting the recommendation that we made on last year's visit around treatment. We reviewed all consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act and were pleased to find no issues with the treatment certificates that authorised treatment under the Mental Health Act.

We were told that there was a weekly audit in place to review the treatment certificates, so that these were in line with an individual's prescribed medication and that there was a process to escalate matters where required. We received a copy of the audit tool and were able to see that this was robust and its introduction supported adherence to rights-based care.

We wanted to find out if any individuals who had been admitted to the ward on an informal basis had been prescribed and administered 'if required' intramuscular (IM) psychotropic medication, as we had raised concerns about this practice following some other recent visits in Fife.

Administration of 'if required' IM psychotropic medication almost always requires the legislative authority of the Mental Health Act. The Commission is concerned when IM 'if required' medication is being prescribed for informal patients. This is because it is unlikely that there would be consent to receive this treatment if it had to be administered in circumstances where restraint may be required. We consider it best practice for a medical review to be arranged if there are exceptional circumstances where IM medication may be required. We found one person who had been prescribed IM Medication on admission, however this had not been administered and was picked up during the audit by the pharmacist.

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. We were told that there were two people in the ward where a section 47 certificate was in place and both certificates were completed appropriately.

We would expect that all treatment certificates would be stored together, and we found that the ward had a system in place where this was the case.

We were told that no individuals in the ward had their finances managed under Part 4 of the AWI Act.

Rights and restrictions

The door to the ward was locked and there was a locked door notice at the entrance to the ward. We were aware from another visit that the locked door policy was being reviewed, and we will seek an update from senior managers about this.

We wanted to follow up on the recommendation about people's rights and what work the ward had put in place to meet this recommendation. For people who were detained under the Mental Health Act, the Act provides the authority for the person to remain in hospital. For people who had been admitted informally, we saw evidence of nursing staff having discussions with individuals about their rights in their one to one meetings. We suggested to the SCN that to enhance people's rights, the service could consider developing a rights-based care plan.

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.

While on other visits to the acute wards in Fife, we saw a display of the Commission's 'Rights in mind' pathway to support people with their rights on admission. In Ward 2, there was lack of information on display about people's rights.

The ward had good support from the local advocacy organisation, VoiceAbility, and we were pleased to hear that this service was available for everyone and not just for people who were detained under the Mental Health Act.

Most of the individuals we spoke with had a good understanding of their rights. They had access to advocacy services and legal representation where required.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit, no one in the ward had been made a specified person.

When we are reviewing individuals' files, we look 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] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We found some evidence in the care records of where staff had promoted and discussed advance statements with individuals however, this was lacking and in speaking with people, we found that most had no knowledge of this.

Recommendation 2:
Managers must ensure that there are regular discussions throughout an individual's journey where advance statements are discussed and promoted.

Activity and occupation

We would expect to see person-centred activity programmes which are based on a multidisciplinary assessment of everyone's needs and strengths. Such a programme should include, where appropriate, options for activities both on and off the ward and for therapeutic and recreational activity to reflect the social, cultural and religious preferences of each individual.

We wanted to follow up from our visit last year and find out about the investment that NHS Fife had made in activity provision in this ward, to support people's recovery.

The ward did not have a dedicated activity therapist in place and there was no provision in place from AHPs to provide this either. Activity provision was being delivered by the ward-based nursing staff, however the availability of this was dependant on clinical activity and while we saw activities happening over the duration of day of our visit, in talking to staff, they told us that activities would tend to be the first task to go if staff had other clinical priorities or were required to cover other areas.

We continue to be concerned about the lack of activity provision and requested a further update from senior managers. We were told that there had been ongoing discussions with the AHP manager about the repurpose of posts across the Health Board in order to contribute and deliver on therapeutic activity provision across wards.

We were informed on this visit that approval was now in place to go ahead with creating posts, and these posts had already gone out for advert. We were also informed that these posts were from existing funding. We will continue to request an update from senior managers and look forward to seeing the implementation of activity provision across all the wards.

The physical environment

The layout of the ward consists of single bedrooms and dormitory style areas.

There was a communal sitting area that had sofas and a television, and this was where people ate their meals. This area was in need of upgrading and we had been told that the floor was due to be replaced. Although this had not yet happened, it was on the programme for change.

Recommendation 3:
Managers must replace the flooring in the dining area as a matter of priority.

While some individuals told us that they did not mind sharing their bedspace with others, some told us that there was lack of privacy, particularly when they had to share dormitories and bathrooms.

People told us about the lack of space in the ward, where at times, it could be difficult to find a quiet place.

We were pleased to hear about the reduced numbers being admitted to the ward which meant less people at times in the dormitory. We heard from individuals and staff about the noise coming from the adjoining ward. We heard this on the day of the visit and were aware that Ward 1 was being refurbished.

We raised a concern at the end of day feedback meeting about the door in the dining room which led to the adjacent ward that was being refurbished and was not covered; this meant that there was a potential for dust and debris to enter Ward 2. There was also no signage that gave warning of the building works. Managers agreed to look into this matter further.

There was access to an enclosed patio from the dining/lounge area. Everyone that we observed using this space used it for vaping and smoking. We were disappointed to see the garden being used by people who smoked, and we also heard this from other individuals.

We asked the senior managers about this, given that there is and has been legislation in place for several years prohibiting smoking within 15 metres of a hospital building in Scotland. We were told that it has been difficult to implement this however, staff continued to remind people of the no smoking policy and managers were already thinking about how to address this when the Ward 1 refurbishment is finished, as the outdoor space is shared.

Recommendation 4:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

We are aware that there is a programme of works across the Fife estate that is looking into requirements across the wards. We will request an update from senior managers about this and what works or changes are planned for this ward.

Summary of recommendations

Recommendation1:
Managers must ensure that there is psychology provision available to the individuals in the ward.

Recommendation 2:
Managers must ensure that there are regular discussion throughout an individual's journey where advance statements are discussed and promoted.

Recommendation 3:
Managers must replace the flooring in the dining area as a matter of priority.

Recommendation 4:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

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.

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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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