Mental Welfare Commission for Scotland

Report on unannounced visit to: Leven, Garry and Tummel Wards, Murray Royal Hospital, Muirhall Road, Perth, PH2 7BH

Date of visit: 12 January 2016

Where we visited

The Mental Welfare Commission visited Leven, Garry and Tummel wards, the old age psychiatry wards at Murray Royal Hospital. Garry and Tummel wards are both 12 bedded dementia admission units, and are mixed sex wards. Leven ward is a 14 bed functional admissions unit, and is also a mixed sex ward. All three wards are part of the new build hospital facility at Murray Royal Hospital.

We last visited this service on 28 February 2013, and made recommendations relating to recording information where a patient has an attorney or guardian, the completion of s47 certificates and the availability of information leaflets about the dementia wards.

On the day of this visit we wanted to look at the care and treatment provided generally in the wards, because it had been almost three years since our previous local visit.

Who we met with

We met with six patients and onerelative in the wards. We reviewed the files and care plans for these six patients and also reviewed files for nine other patients across the three wards.

In addition we met with the clinical nurse manager at the end of the visit.

Commission visitors

Ian Cairns, Social Work Officer and Coordinator

Douglas Seath, Nursing Officer

Dr Steven Morgan, Medical Officer

What people told us and what we found

Care, treatment, support and participation

Apart from one person who was clearly unhappy being in hospital, the patients and relatives who we talked to during the visit spoke positively about the care and treatment provided by staff in the ward. We heard specific comments about staff being approachable and friendly, and we observed positive interactions between staff and patients during the time we spent in the wards.

Care Planning

We reviewed care planning documentation for 15 patients in the three wards during the visit. Overall we found that care plans were variable and inconsistent. Some plans did identify the nature of the individual's needs and preferences but in a

number of cases plans were very generic and lacked appropriate person centred information. In some cases we would also have expected to see more care plans in place, to reflect the specific care needs of the individual patient. Team reviews were being well recorded in files.

We did speak to the clinical nurse manager about this issue at the end of the visit and were told that the new head of nursing who had just come into post, is already looking at care planning and quality assurance issues.

Recommendation 1

Managers should ensure they audit care plans regularly, focussing on the personalisation and consistency of recording in plans.

General Health Care

As was the case on our previous visits to these wards we felt that good attention was being paid to meeting patients' physical healthcare needs, with good links with general medical services at Perth Royal Infirmary.

There was also good input from occupational therapy and physiotherapy services on the wards and detailed individual assessments from these professions seemed to be in place where appropriate.

Use of mental health and incapacity legislation

Relevant mental health and incapacity documentation was seen in files, with details of welfare proxies recorded when a guardian or attorney was in place for a patient.

We saw that s47 certificates were in place and were filed consistently. We did find some issues relating to the authorisation of medication for several patients in Tummel Ward. We reviewed T3 forms, the forms completed by a Designated Medical Practitioner to authorise medical treatment when a patient is detained and refuses consent or is incapable of consenting. In one case the T3 form did not reflect changes to the treatment plan which had been made, and in other cases as required intramuscular medication was prescribed for sedation, when patients were informal patients. The Commission's view is that it is very unlikely that a patient will be consenting to receive medication if IM medication is felt to be necessary because of agitation. The medication issues were discussed with the ward manager on the day and they have also been followed up with a letter to the consultant psychiatrist.

Rights and restrictions

In our file reviews we did see that medication was being administered covertly to one patient. We were pleased to see in this case that a covert medication pathway was being used appropriately.

On the day of the visit the door in Garry ward was locked. There was no notice near the door explaining why it was locked or how someone could leave the ward.

Recommendation 2

Managers should ensure that there is accessible information about the locked door policy and about why the doors to wards are locked.

Activity and occupation

We were able to talk to people about activities in the wards and they spoke positively about the activities available. We also saw evidence that activity provision was well supported, and we saw information in the wards about the range of activities being provided.

The physical environment

As mentioned earlier in the report, these wards are part of the new build facility in Murray Royal Hospital and all three wards are spacious and clean, with a lot of natural light and good access to outside space and fresh air. We also heard on the day about what is being done to produce artwork to be displayed, to ensure that the environment is not overly clinical.

One patient mentioned that the TV signal in the wards is very poor and that this causes the TV screens to freeze regularly. This was mentioned to the clinical manager, who was aware of the problem and said this was being addressed.

Any other comments

Patients in the wards can use cafeteria facilities at the entrance to the building, although opening times for the cafe are quite limited. One patient told us that the drink vending machines, which are accessible at all times, have often not been working simply because the machines needed to be filled with cups. This was brought to the attention of the manager at the end of the visit, and will be followed up.

Three female patients, who had a mental illness but not dementia, were in Tummel ward, one of the dementia wards, on the day of the visit. These patients would normally have been in Leven ward, but had to be admitted to Tummel ward because the beds in Leven ward were full. All three patients told us on the day that at times they did feel unsafe in the ward because of specific male patients who could be very noisy, or could display disinhibited behaviours. The female patients did tell us that staff on the ward were approachable and supportive and responded promptly if another patient was disinhibited or noisy. These female patients said clearly though, that they would have preferred to be in a different ward and that they did find it stressful if particular patients were being very noisy or displaying unpredictable behaviours.

This issue was discussed with the clinical manager at the end of the visit. We were told that the new head of nursing for the service has initiated a review of nursing rotas, looking at how patients' needs in wards are reflected in the staff rotas. We were also told that service managers have identified that there is a need to look at the configuration of the three wards, nursing rosters on the wards, and the number of dementia beds required for the service and these are currently being looked at. There has also been a significant number of people in the wards waiting to be discharged and this is an issue which is being discussed with local authority partners.

Recommendation 3

The managers should ensure that they take account of patients' views about safety on the wards as part of the review of the ward configurations.

Summary of recommendations

1. Managers should ensure they audit care plans regularly, focussing on the personalisation and consistency of recording in plans.

2. Managers should ensure that there is accessible information about the locked door policy, and about why the doors to wards are locked.

3. The managers should ensure that they take account of patients' views about safety on the wards as part of the review of the ward configurations.

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.

Kate Fearnley

Executive Director (Engagement & Participation)

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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