Mental Welfare Commission for Scotland

Report on unannounced visit to:
Murray Royal Hospital, Moredun Ward, Muirhall Road, Perth, PH2 7BH

Date of visit: 20 January 2025

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

Moredun Ward is a 22-bedded, mixed sex ward that provides acute mental health admission and assessment for adults. On the day of our visit, there were 18 people on the ward and four individuals were on home pass; there were no vacant beds.

Moredun Ward is based in Murray Royal Hospital and provides admission and assessment for acute inpatient mental health care for adults in the Tayside area.

We last visited this service in December 2023 on an announced visit and made recommendations that one-to-one discussions were recorded in care records, additional registered nursing staff were recruited, psychotropic medication was legally and appropriately authorised, that medical and nursing staff understood their responsibilities and accountability regarding prescribing and administering psychotropic medication, the locked door policy was explained to individuals in the ward, observation of the ward environment was improved to provide a safe environment and the NHS Tayside smoking policy was explained and complied with by all staff and individuals in the ward.

The response we received from the service was that one-to-one discussions would be highlighted as such in care records to clearly identify when one-to-one interaction with individuals takes place, that three full-time Band 5 staff nurses were due to start in Moredun Ward in October 2024 and funding was in place to recruit more through additional advertising. We were also told that weekly and monthly checks were in place by nursing and pharmacy staff to audit Part 16 documentation, that nursing and medical staff would discuss the locked door policy and access and egress with individuals on admission and that a leaflet on the locked door policy would be produced.

We were advised that daily staffing levels were to be increased by one health care support worker (HCSW), to support the duties of the floor nurse and that the nursing office in the female side of the ward would continue to be used to provide enhanced awareness of that area.

Lastly, individuals and staff were to be reminded of the clear directions in the NHS regarding no smoking legislation, with new signage to be put in place around the ward to reinforce that there was no smoking in hospital environments. Individuals and staff would be offered advice and smoking cessation interventions and there was a short life working group, with health psychology involved with supporting Murray Royal Hospital to be smoke free.

On the day of this visit, we wanted to follow up on the progress with the previous recommendations, to meet with people receiving care and treatment on Moredun Ward and to review their care and treatment.

Who we met with

We met with, and reviewed the care of 12 people, six who we met with in person and reviewed six sets of care records.

We spoke with the service manager, the associate nurse director, the senior charge nurse, the charge nurse and the consultant psychiatrist.

Commission visitors

Gordon McNelis, nursing officer

Sandra Rae, social work officer

Tracey Ferguson, social work officer

Jenn McIntosh, student nurse

What people told us and what we found

The individuals we spoke with on the day of our visit gave mostly positive comments about staff. We were told they were “approachable”, “supportive” and “they give me space and help to resolve issues.” We also heard that staff were “trustworthy, despite me having some difficulty trusting people.” Others told us that they felt “safe”, “listened to”, that there was “no negotiation with care and treatment” and that people enjoyed their one-to-one sessions with staff.

Care, treatment, support, and participation

Care records

Information on individuals’ care and treatment was held electronically and easily located on the EMIS system. Our review of these records showed the continuation notes gave the reader a detailed description of the individual’s mental state and presentation on that day.

We wanted to follow up on our previous recommendation regarding recording of one-to-one discussions between individuals and staff. Although we saw evidence that these discussions had taken place, we had some difficulty finding these when using the advised term “#1:1” as referenced in the 2023 action plan. We raised this with staff at our feedback meeting and were advised they would look into this to ensure it was used consistently with staff.

We found detailed risk assessments, but there were no risk management plans in response to these identified risks. The Commission considers that the clinical risk assessment and management plan protocol should be understood and followed by clinicians, especially regarding clinical circumstances under which specific risk assessments and an accompanying management plan are required.

Recommendation 1:

Managers should ensure that risk management plans are developed to reflect the risks identified during risk assessment and throughout the person’s admission.

Care plans

We found nursing care plans to be detailed, person-centred, related to holistic needs of the individual and evidenced by regular reviews. However, we found a mixed account of individuals being aware of, or participating in, the development of their care plans.

We acknowledge that for some individuals, their ability to engage and contribute to care planning may not be possible due to the progression of their illness however, we would have expected this to be documented, with consideration for them to contribute when they are able to. We would like to see documented evidence of whether an individual accepted or declined to participate in developing their care plans at our next visit.

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.

Multidisciplinary team (MDT)
A range of professionals were involved in the provision of care and treatment in the ward. This included psychiatry, nursing staff, HCSWs, occupational therapy (OT) and an activity support worker (ASW).

On the day of the visit, we wanted to follow up on our previous recommendation regarding recruitment of registered mental health nursing (RMN) staff. Although funding was in place for the expected recruitment of three Band 5 RMNs, the recommended requirement was not reached. Funding remains in place to achieve this target through additional advertising of these posts.

Recommendation 2:
Managers should ensure that the recruitment of registered nursing staff remains a key focus point to provide the ward with a balanced skill set.

Although the recruitment of psychology posts in NHS Tayside had been recognised as challenging, we were told individuals were referred to local community mental health team (CMHT) psychology colleagues for input and intervention where this was required. We are of the opinion that dedicated clinical psychology input to Moredun Ward would provide valuable staff guidance and formulation for individuals with challenging and complex needs.

Recommendation 3:
Managers should ensure dedicated clinical psychology input on Moredun Ward to provide clinical interventions to, and psychological formulations for, people on the ward.

We were told the clinical team meeting (CTM) in Moredun Ward took place on a weekly basis with individuals invited to attend. We found the record of an individual's attendance and were told that their views were gathered prior to the meeting. However, we did not see a record of these views being discussed or documented.

We found the CTM records were variable in information and detail with some meetings taking place with minimal staff present. Although we found the CTM record included the designation of those in attendance, we noted this was accompanied with their first names only. Good practice would be to record the full names and designation of those in attendance.

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

Recommendation 4:
Managers should ensure that the full names and designation of those in attendance at the CTM are recorded and that the views of individuals are discussed and the outcome of these discussions recorded.

Use of mental health and incapacity legislation

On the day of the visit, 16 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (AWI Act), including certificates around capacity to consent to treatment, were easily found and in order.

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.

On the day of the visit, we wanted to follow up on our previous recommendation regarding psychotropic medication being legally and appropriately authorised. We were told Part 16 documents were now audited weekly by nursing staff and monthly by pharmacy staff and feedback given to the senior nurse and medical team of any identified issues. During our review of T2 and T3 certificates, we found these in both electronic and hard copy format. We found discrepancies on some T2 certificates, although when we raised this with the charge nurse, we were shown evidence that these had previously been identified during recent audits and had already been actioned to be rectified but that this had not yet happened. We asked the charge nurse to progress this as quickly as possible.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 reviewing the care records, we found an appropriate section 47 certificate in place, however the accompanying treatment plan was missing. We also found multiple expired copies of section 47 certificates on file. This was addressed with ward staff with a view to have this rectified, which we were satisfied would be adhered to.

Rights and restrictions

A locked door policy remained in place for Moredun Ward to provide a safe environment and support the personal safety of everyone on the ward. We were

satisfied that this was proportionate in relation to the needs for most of those in the ward.

On the day of the visit, we wanted to follow up on our previous recommendation regarding the locked door policy being explained to individuals in the ward. We were told nursing and medical staff discussed the locked door policy, along with the process for access and egress from the ward, with the individuals who were admitted to Moredun Ward. We saw some evidence of these discussions in the care records. We were disappointed to see that there was still no notification on display that Moredun Ward had a locked door policy in place.

Recommendation 5:
Managers should ensure that the locked door policy and protocol on door locking is clearly visible and available to individuals, visitors and staff. This should include information on how individuals who are informally admitted to the ward can come and go freely.

Activity and occupation

Moredun Ward had activities that were facilitated by both OT and ASW. The activities for the week ahead were available to view in an activity timetable. Activities included yoga, arts and crafts, including pottery classes, cooking and baking classes and a breakfast group.

There was emphasis placed on the individuals' physical health, and we heard from people on the ward that "there are plenty of activities if folk wish to take part", that "the OT is always encouraging people to get involved" and the ASW is "positive" and "always available".

We found the care records gave a detailed description of the activities that were offered to individuals, and despite variable levels of participation, whether people accepted or declined to participate was documented.

The physical environment

The layout of the ward consisted of single en-suite rooms, with males and females sited on different sides of the ward. The ward was welcoming, bright and airy, with colourful artwork on the corridor walls and a good amount of space and storage available throughout.

We saw posters signposting individuals and visitors to helpful community resources.

There was a well-maintained courtyard garden which individuals had access to during the day and additional, separate gardens for both males and females.

The layout of the ward had been highlighted in previous reports and included in recommendations, noting the difficulty of maintaining observation. On the day of this

visit, we wanted to follow up on the previous recommendations regarding suitable observation of the ward to provide a safe environment. We were told the 'floor nurse' role situated in the both the male and female sides were protected and that the daily staffing levels were increased by one HCSW to support the duties of these floor nurses to provide enhanced awareness of each area.

When individuals were admitted and there was no bed immediately available for them, they could be accommodated in a 'surge bed'. Moredun Ward had access to two additional rooms for surge capacity. On the day of our visit, the surge beds were not in use.

Our previous visit reports to Moredun Ward have highlighted the non-compliance with the Scottish Government's NHS no smoking legislation. This resulted in an action plan response that indicated this was explained and complied with by all individuals and staff. The response from the service detailed how NHS Tayside planned to ensure compliance with this legislation, including the provision of education, advice, smoking cessation interventions and signage.

We were also told there was a short life working group that included health psychology to support Murray Royal Hospital being smoke free. On the day of this visit, we wanted to follow up on the previous recommendation and despite the robust action plan supplied by the service, we were disappointed and concerned that there continues to be difficulty in implementing the smoke free legislation.

Recommendation 6:
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.

Summary of recommendations

Recommendation 1:
Managers should ensure that risk management plans are developed to reflect the risks identified during risk assessment and throughout the person's admission.

Recommendation 2:
Managers should ensure that the recruitment of registered nursing staff remains a key focus point to provide the ward with a balanced skill set.

Recommendation 3:
Managers should ensure dedicated clinical psychology input on Moredun Ward to provide clinical interventions to and psychological formulations for people on the ward.

Recommendation 4:
Managers should ensure that the full names and designation of those in attendance at the CTM are recorded and that the views of individuals are discussed and the outcome of these discussions recorded.

Recommendation 5:
Managers should ensure that the locked door policy and protocol on door locking is clearly visible and available to individuals, visitors and staff. This should include information on how individuals who are informally admitted to the ward can come and go freely.

Recommendation 6:
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.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk