Mental Welfare Commission for Scotland

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

Date of visit: 28 July 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

Tummel Ward is a 12-bedded, mixed-sex ward in Murray Royal Hospital that provides assessment and treatment for older adults, over the age of 65 with a dementia diagnosis. Tummel Ward primarily admits people from across the Perth and Kinross area. This ranges from Kinross in the south, Perth city and Blair Atholl in the north.

On the day of our visit, there were 11 people on the ward with one person boarding out at a medical ward. Two individuals were delayed from being discharged from the ward as they were awaiting care packages.

We last visited the service in July 2024 on an announced visit. We made recommendations that nursing staff should document descriptions of individuals presentation and also of their engagement with activities in the clinical records. The response we received from the service was that they had introduced audits to ensure both recommendations were addressed.

On the day of this unannounced visit, we wanted to meet with individuals and speak with their relatives. We wanted to ensure that care and treatment was being provided in line with mental health legislation and in a human rights compliant model.

Since our last visit we had been alerted to one significant incident, and we were aware that the service was planning to carry out a learning review (LR). We will review this report on completion and follow up with the service accordingly. We made enquiries regarding any falls that resulted in harm since our last visit. It was confirmed that two falls had occurred in the last year.

We were informed since our last visit there had been a new IT system introduced. We were keen to hear how staff were dealing with the transition to this new system. We were informed that there was a small number of nursing vacancies in the ward with plans in place to recruit.

Who we met with

We met with three people and reviewed the care records of five people.

We spoke with the senior charge nurse (SCN), charge nurse, activity support worker (ASW) and other nursing staff.

Commission visitors

Justin McNicholl, social work officer

Gordon McNelis, nursing officer

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included contact with staff, participation in their care and treatment, activities that were available to them and their views of the environment. We were also keen to review the plans for individuals who had been in the ward for a considerable period and those who were experiencing their first admission to a mental health service.

The longest admission to the ward had been for 11 months, with most individuals experiencing short admissions to the ward, on average between two to three months. There were nine individuals who were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) with the rest being admitted informally. There were no individuals who were subject to continuous interventions.

All those that we met with praised the care and treatment being delivered to them by the staff in Tummel Ward. We were advised that staff were, “nice”, “very good” and “kind”. One individual stated, “they are great, they can’t do enough for you”. All the individuals that we spoke to described feeling “safe” and how all the staff were “approachable” and “relaxed”.

Several individuals in the ward were too unwell to speak with us directly. Despite this, we were able to observe the care being delivered to them; we found that this was provided in a sensitive manner that respected individuals’ dignity. Throughout the day we witnessed various steps taken to engage individuals on a one-to-one level to participate in the various activities on offer.

We spoke to several staff during our time on the ward. We received several comments which included, "I love working here", "I wouldn't want to work anywhere else" and "staff work hard to provide the best care to the patients". These comments were further illustrated by the calm and caring approaches delivered by staff. We heard of the challenges staff faced in finding the correct number of chairs and couches to support individuals across a variety of rooms in the ward. This resulted in staff regularly having to lift chairs around the ward to support individuals in whichever rooms they found themselves. The lack of appropriate seating with arm rests was reported to be due to damage and general wear and tear. We heard from the senior charge nurse that a bid had been made to replace some of the couches and chairs, but no funding had yet been approved.

Recommendation 1:
Management should ensure that swift action is taken to provide appropriate seating for all individuals throughout the ward.

We heard that the ward has been facing a significant challenge recently due to the lack of a lead medical professional. Staff spoke of the various steps taken by

managers to address this gap in medical cover by ensuring reviews were completed by junior and senior medical staff. There were plans in place to employ a locum psychiatrist to the ward in August 2026. When we next visit, we look forward to seeing how this will help to stabilise the medical provision.

All the individuals that we spoke to praised the food and portion sizes on offer describing it as “good”, “fine” and “just to my liking”.

Care, treatment, support, and participation

NHS Tayside uses the MORSE electronic record and we were able to review the clinical records for those in Tummel Ward. The clinical team had been trained in using this new system, which went live in the last year.

We reviewed care plans, risk assessments and risk management plans. We discussed and considered the value and the need to capture the individual’s social history. During the visit we found some individuals had a ‘getting to know me’ document recorded in their paper record. These had been completed with individuals or by their relatives. A small number had no completed documentation due to their inability to complete the forms or having no next of kin; of the information we reviewed, we found that this useful document helped to inform the team on how best to support individuals, with their wishes and preferences taken into consideration. We also found relevant life history information documented in initial assessments, care plans, risk assessments and letters written between medical clinicians.

Tummel Ward used two tools to record individuals’ risks. These include the mental health/learning disability risk assessment form which was a tick box approach that noted the key risks that individuals faced/presented with, with a section for formulation of the factors identified. The second tool was a risk assessment and management plan which recorded steps to ensure safety of individuals, and these were to be reviewed accordingly.

For most of these documents we reviewed, we found these to be completed with a clear summary of how to manage the changing needs of the individuals in the ward. We found one record that had not been fully completed, and this was highlighted to the staff at the time of the visit. We heard that there were plans to update the risk assessment process in the coming year which will result in a single tool which will be uploaded to the MORSE system. We look forward to seeing how the introduction of one approach impacts on the recording and analysis of risk when we next visit the ward.

Care records

Information on individuals care and treatment was easily located on MORSE and staff told us that in general, the system worked well and was a noted improvement from the previous electronic system. Each individual had an electronic record and

had a brief paper record held in the nurse's station. The paper record provided easy access to admission paperwork, copies of the 'getting to know' document, Mental Health Act and AWI Act paperwork, as well as some physical health monitoring documentation.

Care plans

Care plans are a tool that identify detailed plans of care and intervention; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

We found that individuals in the wards had care plans in place to support outcomes and identified plans. These were found to be personalised, up to date and regularly reviewed. Some of the reviews were basic, but they were sufficient to ensure that there was a clear understanding of progress towards any identified outcomes.

We found each care plan had clear interventions and actions in place. The care plans ensured that both mental health and physical health needs were considered and were written in way to clearly show the difference that the input from various professionals was making to individuals. We found separate pharmacy care plans on MORSE which helped to demonstrate that all medication was monitored and reviewed for the benefit of the individual.

Multidisciplinary team (MDT)

A range of professionals are involved in the provision of care and treatment in the ward. This includes junior doctors, all grades of nursing staff, occupational therapy, (OT), pharmacy, a transitional care nurse (TCN), an ASW, mental health officers (MHOs) and social workers (SWs). Although there was no dedicated psychologist for the ward, we were told Tummel Ward had regular input from psychology to provide formulations which supported and managed stress and distress.

The one significant gap found during this visit was the absence of MDT meetings occurring over the last three weeks. This was due to the lack of senior psychiatric medical provision. Due to this absence the ward had adopted the approach of holding 'board round' meetings. This allowed for nursing, junior medical staff and pharmacy to discuss progress. We found these meetings were not occurring on a consistent basis and were not recorded in all the clinical records. There was no agreed template for these meetings and there was variation in each record we reviewed. This lack of consistent MDT reviews and recording what progress had been made was a concern. We are aware there are plans in place to address the absence of a lead psychiatrist for the ward in the coming month. However, the current situation is of significant concern. At present the managers have arranged temporary medical cover from another ward in the hospital to ensure that duties under the Mental Health Act are fulfilled in line with legislative responsibilities. We found no immediate concerns that these duties were not being fulfilled.

Recommendation 2:
Managers must ensure that a psychiatrist is appointed to the ward to ensure consistent MDT meetings are re-established.

Despite the lack of a consultant psychiatrist, we did find evidence that progress towards discharge continued to be addressed at pace. This included SW staff ensuring care packages were in place and OT staff were supporting home visits.

We did note that no individuals or relatives were invited to the board round or previous MDT meetings. We found that relatives were offered opportunities to meet with the team to discuss updates, discharge planning meetings or to address any concerns they had.

We asked about the two individuals whose discharges were delayed. We were told that there were challenges with the provision of suitable care packages for both individuals that would support them to move on.

We heard of some gaps in the physiotherapy provision to the ward but there were plans in place to address this.

On the day of the visit, Tummel Ward had sufficient staffing numbers. Usually there were five members of staff on shift during the day with two registered nurses and three healthcare support workers. At nighttime the staffing numbers reduced to two registered nurses and two healthcare support workers. When there was an increased clinical acuity in the ward, staff numbers increased to six. We were informed that in the last few months the ward had relied on agency staff to aid with ensuring sufficient staffing levels. However, input from agency staff was not always guaranteed which did on occasion leave gaps in the staffing rota. We were informed that on one occasion the ward dropped below the standard staffing number of four staff to two, due to sick leave and unplanned absences. It was confirmed that a Datix report was completed for this incident and there have been no further incidents since this time. We heard that staff had been moved from Garry and Leven Wards to help to ensure sufficient staffing levels. The SCN spoke of the steps being taken to address the staffing gaps with recruitment of nursing staff planned for the coming month.

We found on record five ‘do not to attempt cardiopulmonary resuscitation’ (DNACPR) certificates. These were stored in the individuals’ paper record. There was clear consultation by the medical officer completing the DNACPR document with the nearest relative, power of attorney or guardian. We spoke to one individual for which a DNACPR was in place, who expressed that they did not believe they were subject to one. We requested that the SCN ensure the situation and certificate was reviewed by medical staff urgently to avoid any confusion.

From reviewing the electronic records, we found templates had been created to ensure that consistent accurate information was recorded. There was evidence that psychiatry, nursing, pharmacy, OT and ASW input was recorded on a consistent basis. This co-location of electronic information helped aid with care planning and any planned intervention delivered by a member of the team. We found, compared to our previous visit, that the daily recordings provided a detailed description of the individual's current mental state and their views about engagement with treatment and activities.

There were some gaps in the views of family members being taken into consideration to deliver the best outcome for the individual and we found that information about this was lacking in the care records we reviewed.

Recommendation 3:
Managers should review their processes to improve the recording of relatives and carers views and ensure these are fully integrated to deliver the best outcomes for individuals.

Use of mental health and incapacity legislation

On the day of the visit, nine people were detained under the Mental Health Act on Tummel Ward. All individuals were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment was easily located and in good 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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. We were told these were reviewed by pharmacy monthly.

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 follows the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

We reviewed all section 47 certificates and treatment plans. These forms were found to be individualised and in date. Some of the section 47 certificates had been agreed with the relatives, POA or guardian and signed by these people which was good practice, however we did find four section 47 certificates in which consultation or the

nearest relative, primary care, power or attorney (POA) or guardian had not taken place.

Recommendation 4:
Managers must ensure that there are audits of s47 certificates completed to ensure clear consultation, recording and engagement with nearest relatives, primary carers, powers of attorney and guardians to ensure compliance with the requirements of the AWI Act.

For individuals who received medication covertly, we found the covert medication care pathway documents in order and they included an easy-to-understand rationale and instruction from pharmacy.

We reviewed all records to confirm whether copies of power of attorney and welfare guardianship orders were held on file. This was found to be the case with each document printed and stored in the individual paper file.

Rights and restrictions

A locked door policy remained in place at Tummel Ward to ensure a safe environment and support everyone's personal safety. We were satisfied that this was proportionate in relation to the needs for most of the individuals on the ward. We saw appropriate use of signage advising people of the locked door policy restrictions in place.

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 made a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied. No specified person restrictions were in place at the time of our visit.

The individuals that we spoke to were aware of their current legal status and those who were voluntarily admitted to the ward were aware of their rights, their ability to access advocacy and expressed clear willingness to accept treatment on an informal basis.

Similar to our last visit, the ward continued to promote access to advocacy services and we were advised that advocacy visited regularly and staff could also refer individuals to the advocacy service at the time of admission.

Activity and occupation

Tummel Ward has input from a designated ASW who aimed to provide support for all individuals which focused on their preferences and interests. These included quizzes, walks, games groups, listening to music and social occasions that could be facilitated either individually or in a group.

A recent garden concert had taken place; the individuals that we spoke to praised the entertainment that was on offer. A therapet visited the ward usually once per week and therapeutic groups were also available, with one-to-one hand massages and relaxation sessions.

We found documented entries of the various opportunities taking place on MORSE. OT staff also provided individualised, focused, structured and therapeutic activities that promoted and taught skills that were transferable to outside living. These included use of the activities of daily living kitchen, as well as having a focus on improving the physical health of individuals with seated and strengthening exercises.

We were able to observe some of the available activities, including a dominoes session and the use of reborn dolls which delivered comfort and therapeutic care. The individuals and staff we spoke with were complimentary about the ASW and positive about the activity and occupation available on the ward. We found the ASW to be enthusiastic and inventive in their approach.

The physical environment

The layout in Tummel Ward remains unchanged since our last visit, with individuals having single en-suite rooms. We noted the effort made in the ward to provide a dementia-friendly environment. There were large artwork prints decorating corridor walls which provided pictures of trees and various woodland images. These contributed to a welcoming, calm and warm environment, not only for the individuals in the ward, but for also visiting family, relatives and staff. We noted that there were memory walls doted throughout the ward to help with reminiscence.

We were advised of some issues the ward was facing with their bedroom sensory alarms. These were supposed to trigger staff when individuals got up from their beds and walked around their bedroom. It was discovered in the last year that these had not been working properly. As a result, a second bed alarm had been installed to ensure that staff were alerted to all movements. There were plans in place to discuss with the hospital contractor to potentially install alarms on the ceiling of the bedrooms. This would help to further alert staff to any movements which could help prevent falls and minimise any risks to individuals.

The ward had access to two garden spaces. The first was an internal courtyard which was solely for the use of individuals in Tummel Ward and was maintained by the ASW and OT staff; we found this space to be bright, welcoming and tidy. The second was a dementia friendly garden, shared with another ward. There were various exercise stations located throughout the garden which staff encouraged individuals to use for stretching and exercise. The door to the garden was closed throughout the day and access provided as required.

Any other comments

We were advised of the ward management team working to implement a new vision and values statement for Tummel Ward. This aimed to focus on delivering compassionate, person-centred and dementia-informed care. We look forward to hearing when we next visit how this has been embedded into the ward.

Summary of recommendations

Recommendation 1:
Management should ensure that swift action is taken to provide appropriate seating for all individuals throughout the ward.

Recommendation 2:
Managers must ensure that a psychiatrist is appointed to the ward to ensure consistent MDT meetings are re-established.

Recommendation 3:
Managers should review their processes to improve the recording of relatives and carers views and ensure these are fully integrated to deliver the best outcomes for individuals.

Recommendation 4:
Managers must ensure that there are audits of s47 certificates completed to ensure clear consultation, recording and engagement with nearest relatives, primary carers, powers of attorney and guardians to ensure compliance with the requirements of the AWI Act.

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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