

**Mental Welfare Commission for Scotland**

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

**Date of visit:** 7 June 2017

## **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 bed 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 12 January 2016, and made recommendations about care planning, about their locked door policy, and about consultation with patients as part of a review of the ward configurations.

On the day of this visit we wanted to look at care planning, but also to look generally at the provision of care and treatment in the three wards, because it had been almost 18 months since our previous visit.

## **Who we met with**

We met with and or reviewed the care and treatment of 13 patients and also spoke with three relatives or friends.

We spoke with service managers and charge nurses in the three wards at the end of the visit.

## **Commission visitors**

Ian Cairns, Social Work Officer and Visit Coordinator

Douglas Seath, Nursing Officer

Tony Jevon, Social Work Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

It was difficult to have detailed conversations with many of the patients in Garry and Tummel Wards, because of the progression of their dementia. We did speak to more patients in Leven ward, who were able to tell us about their experience receiving care and treatment in that ward. We observed the care and treatment being provided in the three wards during our visit, and patients appeared to be well looked after. When we could talk to people about their care and treatment in the wards they spoke positively about staff, and about how they felt staff were attentive and approachable. Relatives we met in all three wards also spoke highly about the care and treatment being provided, and the attitudes of staff. We heard various comments from relatives about staff being kind and caring, and we also heard from several relatives that they felt staff keep them very well informed. The partner of one patient who had been recently admitted also described how nursing staff had given them very helpful

practical information at the time of admission about the ward, about visiting, and about things like parking at the hospital.

When we reviewed files we found that information in the care planning section in the electronic records system was variable, and in some cases care plans were limited with very little personalised information. We were aware though that a lot of work has been undertaken in the three wards looking at formulation care planning, the process of formulating and taking decisions about a patients needs and the goals for treatment.

We saw formulation plans in the electronic record, and these were generally much more detailed than the individual care plans, with clear personalised information about interventions required to meet the needs of each patient. This meant that when we read care plans in conjunction with formulation plans, and often in conjunction with risk assessments and risk management plans as well, we did get a clearer picture of how care and treatment was being provided to meet individual needs.

The Commission is aware that NHS Tayside is about to introduce a new electronic records system in mental health services, later this year. It has been acknowledged that the structure of the current electronic system has not allowed staff to collate information easily into a written care plan. This has meant that staff have had to record care planning information in different sections of the current system, which we saw in these three wards was being done in detailed formulation plans.

#### **Recommendation 1:**

Managers should ensure that the new electronic records system, as it is introduced, has a structure which allows care planning information to be recorded consistently.

While reviewing files we took the opportunity to look at daily progress notes, and at the documentation for multidisciplinary team (MDT) reviews. We were pleased to see that the one to one time nurses spent with individual patients could be easily identified in daily notes. MDT meetings were recorded well, and indicated any actions which had been agreed at these meetings. We did see though that many MDT recording sheets did not include information about who was in attendance at meetings, and we feel that this information should be recorded routinely. We also heard from patients that they did attend review meetings which were arranged to discuss future plans, including plans for moving on from hospital. However they did not attend the weekly MDT meetings, and this issue was discussed with managers at the end of the visit. The Commission was told that the practice in all three wards is that patients will not be asked to participate in the weekly MDT meetings, because experience has been that many patients find participation in these meetings stressful. Patients and/or relatives will be given feedback from the MDT meetings. The Commission's view is that there should not be a blanket approach to the participation of patients in the MDT meetings, but the decisions about inviting patients or relatives to contribute to these meetings should be taken on an individual case by case basis.

## **Recommendation 2:**

Managers should review how patients and/or relatives can be enabled to participate in the MDT meetings where this would be appropriate.

## **Use of mental health and incapacity legislation**

We found paperwork in relation to patients detained under the Mental Health (Care & Treatment) (Scotland) Act 2003 was up to date and easy to locate within files. We reviewed T3 forms, the form completed by a designated medical practitioner (DMP) to authorise treatment when a patient is detained and refuses consent or is incapable of consenting. We did see that in one case where a T3 form was in place the visit by the DMP should have been arranged several weeks before the actual visit. We also saw that one patient who had previously been subject to compulsory measures but who was now an informal patient was still prescribed an intramuscular medication for sedation, although this had not been administered since compulsory measures had lapsed. Both these issues were mentioned to managers at the end of the visit, and the issue about monitoring authorisation for medication will be discussed with the pharmacist who has input into the ward.

Details of welfare proxies were recorded in files when a guardian or attorney was in place, and we saw copies of welfare guardianship orders and powers of attorney in files. Where an individual lacks capacity to make a decision in relation to medical treatment not authorised under the Mental Health Act a certificate under Section 47 of the Adults with Incapacity Act must be completed to authorise that treatment. We saw Section 47 certificates with treatment plans in place in files reviewed. We also saw do not attempt cardiopulmonary resuscitation (DNACPR) forms in files, with information to indicate that DNACPR decisions had been discussed with relatives or guardians or attorneys.

## **Rights and restrictions**

External doors to wards were locked for reasons of safety but we did not find this causing distress to any patients or inconvenience to visitors, and information about locked doors was displayed at the entrances. In addition to a spacious ward environment, patients had free access to outside areas, with good garden spaces which effectively augmented the available areas for walking and activity.

## **Activity and occupation**

We were able to talk to a number of patients about activities in the wards. Several patients acknowledged that they did not feel able at the time of our visit to engage in activities, because of their poor mental health, and that they preferred spending time in their own bedrooms. Information about planned activities was available in each ward, and we heard that there were discussions taking place with the voluntary services coordinator in the hospital about support volunteers may be able to provide

with activity provision in the wards. We did note that there had previously been an activity coordinator post within the wards, but that this post has been deleted. We did feel that nursing staff in the three wards are providing care and treatment to people who often have complex needs and significant physical health problems, and that it will be difficult for nursing staff to undertake planned activities with patients, in addition to clinical duties.

### **Recommendation 3:**

Managers should audit the provision of activities in the three wards, and look at options for enhancing activity provision.

### **The physical environment**

These three wards are part of a new facility at Murray Royal Hospital, and all the wards are spacious and clean, with lots of natural light and good access to an outside space and to fresh air. On our previous visit we had heard that work was being done to produce artwork to be displayed in the wards. This work is still in progress, involving students from Perth College, but we did see some of the completed artwork on our visit.

Following a recent infection control inspection some furniture in the wards was condemned. Some of the furniture in communal areas has to be replaced, and some old chairs and sofas have already been removed from wards. This furniture has still to be replaced though, and we saw that in specific quiet lounges there was limited seating available.

### **Recommendation 4:**

Managers should ensure that furniture which has been identified as needing replaced is replaced as soon as possible, and that wards are not left without adequate seating if old furniture is removed.

### **Any other comments**

There seems to be good input from the local independent advocacy service in the wards.

We did see that the board in the nursing station in Tummel Ward which has patient identifiable information could be seen through the observation window from one of the communal areas in the ward. This was discussed with managers at the end of visit, and this issue will be addressed.

## **Summary of recommendations**

1. Managers should ensure that the new electronic records system, as it is introduced, has a structure which allows care planning information to be recorded consistently.
2. Managers should review how patients and/or relatives can be enabled to participate in the MDT meetings where this would be appropriate.
3. Managers should audit the provision of activities in the three wards, and look at options for enhancing activity provision.
4. Managers should ensure that furniture which has been identified as needing replaced is replaced as soon as possible, and that wards are not left without adequate seating if old furniture is removed.

## **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.

**ALISON THOMSON**

**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 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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