

Mental Welfare Commission for Scotland

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

Date of visit: 22 February 2018

Where we visited

Moredun Ward is a mixed sex adult acute admission ward with 24 beds. We last visited this service on a local visit on 22 October 2015, and made recommendations about care planning and patient involvement in multidisciplinary reviews. We also visited Moredun Ward on 3 August 2016, as part of a themed visit to adult acute wards across Scotland.

On the day of this visit we wanted to look generally at the care and support provided in the ward, because it was over two years since our previous local visit

Who we met with

We met with and/or reviewed the care and treatment of seven patients and met with one relative. We also met one patient who had recently been discharged from the ward, but wanted to meet us and tell us about their care and treatment while they were in the ward.

We spoke with the acting charge nurse, with the psychiatrist who is currently working in the ward, with other members of the nursing team, and with the pharmacist, who was in the ward during our visit.

Commission visitors

Ian Cairns, Social Work Officer and visit coordinator

Alison Thomson, Executive Director (Nursing)

Claire Lamza, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Most patients we met spoke positively about their care and treatment in the ward, and about the support they received from staff. This included one person who had recently been discharged, but who came up to the hospital for our visit because they wanted to tell us how staff had helped them when they were in the ward. Issues raised by other patients and by the relative we met were followed up on the day of the visit in discussion with the ward staff.

Care planning

We looked at the care planning, and risk assessment and risk management documentation for all the people whose cases we reviewed on the visit. Overall we found that care planning documentation was very variable. Risk assessment and risk management plans were evident in files, and there was clearly a strong focus on risk management within the ward. We saw that daily rapid rundown briefings involving staff

were in place, and that multidisciplinary team (MDT) meetings were well recorded. Though in several files, we could not see that needs identified were being carried through into a care planning process, and we could not see details of interventions or of actions to be implemented. While there is a strong focus on risk management within the ward, we would expect to see care plans which have clearer plans of action for care, and of steps to be taken to meet patients and MDT care goals.

Recommendation 1:

Managers should ensure that care plans focus on individual needs, with clear goals/outcomes, and that there are regular audits of care planning documentation.

Use of mental health and incapacity legislation

We reviewed the medication prescribed for all patients detained in the ward under the Mental Health (Care and Treatment) (Scotland) Act 2003. Where necessary, medication prescribed was authorised appropriately, and we saw evidence of good pharmacy input into the ward. We saw that pharmacy reviews are being completed at the point of admission to the ward. We also heard that the pharmacist will provide information to individual patients about prescribed medication, when a patient requests this.

Rights and restrictions

On the day of our visit, several patients were designated as being on modified observation, and we reviewed the files of these patients. This type and level of observation is not defined in existing national guidance and as such, we found that the implementation of modified observation varied from patient to patient. However, there were clear reasons recorded, explaining why patients were on these observations.

The Mental Welfare Commission published a themed visit report, Enhanced Observation, in 2015¹. This report said that in relation to observation levels, there needs to be a balance between maintaining patient safety and respecting privacy and dignity. The Commission would expect a person-centred care plan to be in place and to be regularly reviewed, in relation to a patient's observation level. In the cases we reviewed it was not clear how the observation level was being reviewed, and how modified observation was being tailored to the specific needs of the individual patient.

This issue was discussed with managers at the end of the visit, and the Commission will be sent a copy of the current observation policy which is in place in Moredun Ward.

¹ https://www.mwscot.org.uk/media/239737/enhanced_observation_201415.pdf

Recommendation 2:

Managers should ensure that, when a patient is on modified observation, there is a person-centred care plan in relation to their observation level, and that this is regularly reviewed.

Activity and occupation

We saw that there were opportunities for patients to be involved in structured activities, but we also heard that there has been reduced input from occupational therapy (OT) in the ward recently. This is reducing the availability of both group activities and activities provided on a one-to-one basis with patients. But, we heard that several posts within the OT service are expected to be filled in the near future, which should enhance OT input in the ward.

The physical environment

Moredun Ward is in a new building which opened in 2013. The Commission first visited the new Moredun Ward in December 2013, when we were told that staff had been experiencing problems with the design and layout in the ward almost immediately after the ward opened.

On a further local visit in October 2015, the Commission saw that some changes had been made to the physical environment in the ward. But, we heard from staff and patients that with the layout of the ward, it was still difficult for staff to maintain observation, with patients saying that they did feel at times that staff were remote in the building because of the ward layout.

We saw on this visit that the environment continues to create difficulties in that there are a number of areas in the ward where patients might not easily be able to find staff, and staff might not easily be able to observe patients.

The Commission is aware that decisions have now been taken within NHS Tayside to locate all general adult psychiatry admission wards at the Carseview Centre in Dundee. This means that Moredun Ward will transfer to Dundee, but we were told on the day of this visit that the timescale for this move may be up to two years.

The Commission feels that there continues to be patient safety issues because of the physical layout in Moredun Ward. In particular because the ward layout makes it difficult for staff to observe patients. Until Moredun Ward transfers to Carseview the Commission would expect senior managers in NHS Tayside to make decisions about staffing numbers in the ward which take account of the physical environment and the issues associated with undertaking observation within this environment.

Recommendation 3:

Managers should ensure that staffing numbers within Moredun Ward reflect patient needs and issues relating to the physical environment in the ward.

Summary of recommendations

1. Managers should ensure that care plans focus on individual needs, with clear goals/outcomes, and that there are regular audits of care planning documentation.
2. Managers should ensure that, when a patient is on modified observation, there is a person-centred care plan in relation to their observation level, and that this is regularly reviewed.
3. Managers should ensure that staffing numbers within Moredun Ward reflect patient needs and issues relating to the physical environment in the ward.

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 Thompson
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.

Contact details:

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

telephone: 0131 313 8777

e-mail: enquiries@mwscot.org.uk

website: www.mwscot.org.uk

