Mental Welfare Commission for Scotland

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

Date of visit: 18 July 2024

Where we visited

Garry and Tummel Wards are both 12-bedded, mixed-sex wards that provide assessment and treatment for older adults with dementia, based in Murray Royal Hospital.

On the day of our visit, each ward was at capacity; Garry Ward had seven people in the ward and Tummel Ward had 12 people. At the time of our visit, Garry Ward had five beds closed due to staffing deficits, although we were told these beds would reopen in October 2024, following the recruitment of additional registered mental health nurses.

We last visited the services in January 2023 on an announced visit and made recommendations that nursing staff undertake care plan training, that summative evaluations were included in care plans, that individuals and carers were involved in care planning, that multi-disciplinary team (MDT) meetings included individual and carers, that section 47 treatment plans cover all relevant medical treatments and that solutions were found to ensure individuals were able to look out of the ward windows without their privacy being compromised.

The response we received from the service was care plan training was given to psychiatry of old age nursing staff, that a peer support model was implemented to support regular care plans reviews and audits, that individuals and carers were invited to be involved in person-centred care plans, that a new MDT proforma had been developed and updated by named nurses at MDT meetings and was audited monthly, that a section 47 audit tool was developed that included a review of medical treatment plans, and that one-way privacy windows were in place.

On the day of this visit, we wanted to follow up on the previous recommendations and look at care plans and the new MDT proforma that was in use.

Who we met with

We met with and reviewed the care of 15 people, six who we met with in person and nine who we reviewed the care notes of. We also met with two relatives.

We spoke with the service manager, the senior charge nurse, the charge nurses the lead nurse and both consultant psychiatrists.

Commission visitors

Gordon McNelis, nursing officer

Tracey Ferguson, social work officer

Kathleen Liddell, social work officer

Paul Macquire, nursing officer

What people told us and what we found

The individuals and relatives we spoke with on the day of our visit gave complimentary comments about staff. We heard that staff “were approachable and helpful” and “provided a high level of care”. Individuals felt they were “in capable hands” and that they “liked the activities”, “there’s always something to do” and the “food is excellent”.

We did hear from some that they “don’t want to be on the ward” although despite this, they mentioned that staff were “cheerful” and offered “good chat”.

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 the records found there to be variable quality of the records in both wards, with some continuation notes providing the Commission staff with a detailed clinical description of the individual’s mental state and presentation on that day, while others only gave a basic account. We consider it to be necessary for health professionals to be descriptive when recording clinical information in order that this gives a clear account of whether an individual’s mental health is showing signs of improvement, deterioration or remains unchanged.

Recommendation 1:
Managers should ensure nursing staff document clinical descriptions of an individual’s presentation in care records.

We wanted to follow up on our previous recommendation regarding person-centred care plans. We found nursing care plans used a strengths-based approach where the individual’s abilities were identified and taken into consideration. The care plans were person-centred, informative and related to historical and current needs. They had goals and interventions in place, although despite this, we found that interventions defined by staff were not documented as robustly as we would have expected. We raised this with managers at our end-of-day feedback meeting and will follow this up at our next visit.

Where individuals were unable to participate to their care plans due to the level of cognitive impairment, we found evidence that carers and relatives had been consulted and asked to provide additional information.

We found care plans focused on the individual’s physical health and included referrals to relevant services where required.

Multidisciplinary team (MDT)

A range of professionals were involved in the provision of care and treatment in the wards. This included psychiatry, nursing staff, health care support workers,

occupational therapy (OT), a transitional care nurse and a hospital discharge social worker and assistant. We were told Tummel Ward did not have an activity support worker (ASW) but that there was a dedicated ASW in Garry Ward. Although there was no dedicated psychologist for either ward, we were told Garry Ward had regular input from psychology to provide formulations to support and manage stress and distress.

We wanted to follow up on our previous recommendation regarding MDT meetings being fully documented. We found the MDT proforma provided a record of those in attendance and held information from the meeting, which included the views of those in attendance at MDT. The proforma described the individual's presentation, dietary and sleep patterns as well as the level of mobility of the individual. We noted there was a summary of as required medication that had been used and discussions about future care goals and plans were recorded, which included the agreed actions to achieve these goals.

Use of mental health and incapacity legislation

On the day of the visit, five people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) on Garry Ward and seven in Tummel Ward. All individuals were under 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 were 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 on a monthly basis.

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. We wanted to follow up on our previous recommendation regarding section 47 certificates. These were easy to access, fully completed, with treatment plans in place, and included evidence of consultation with the proxy decision maker.

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 were advised that covert medication care

pathway forms in Tummel Ward had been moved from hard copies to being stored on the hospital electronic prescribing and medicines administration (HEPMA) online system. The Commission considers that good practice would be to have both printed hard copies and online formats available and for these to be stored alongside any Part 16 and section 47 certificates to ensure any medication that is prescribed and dispensed is done so accurately and with the correct legal authorisation in place.

Rights and restrictions

A locked door policy remained in place at both Garry and Tummel Wards 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 the patient group. 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 a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Specified person restrictions were in place under the Mental Health Act for one individual who had restrictions placed on their use of telephones. We found the RES 3 form that was used to notify the Commission of the implementation of the relevant measure to restrict the use of telephones; this had detailed information and the rationale for the restrictions being applied.

We were told that specified persons restrictions were reviewed at the weekly MDT meeting. Although we found evidence of the individual being informed of their specified person status, we were unable to find a reasoned opinion for this. This was raised with managers to ensure the Responsible Medical Officer (RMO) recorded their reasoned opinion, and that the RMO's explanation and rationale is given to the person who is specified, and to their named person if they have one, as well as the Commission. We were assured this this would be followed up as requested.

Both wards promoted and had access to advocacy services. We were advised that advocacy visit the wards once a week and staff could refer individuals to the advocacy service at the time of admission.

Activity and occupation

Garry Ward had activities that were facilitated by both OT and ASW. We saw an area called "activity alley" that had a weekly timetable of the activities on offer for the individuals in this ward. We were pleased to see this planner had large text and was in easy read format. It included a choir group, yoga sessions, a therapet visiting the ward once per week, painting and music groups, and baking and cooking activities.

We were also told individuals were escorted to external activities in the community, such as attending arts and craft groups and social events.

We found activity care plans that were completed by the ASW. These were detailed, regularly reviewed and included consideration of a wide range of activities and the rational for these. We found activities that took place were documented in the individual's continuation notes, including a record of whether the individual accepted or declined to participate.

Tummel Ward had an activity board which showed the nurse led activities on offer. These included quiz and games groups, listening to music and social occasions that could be facilitated as either individually or in a group. A therapet visited the ward once per week and therapeutic groups were also on offer with hand massages and relaxation groups. It was clear there were a range of activities offered to individuals in Tummel Ward, although we had some difficulty finding documented entries of these taking place on EMIS. We would like to have seen a record of the activities that took place recorded in the continuation notes, including whether the individuals accepted or declined to participate.

Recommendation 2:
Managers for Tummel Ward should ensure the activities offered are documented in the individual's case notes and whether they chose to participate or not.

We heard positive comments about activities from individuals in both wards, and although the ASW post in Tummel Ward was vacant at the time of the visit, we were told this was being recruited to. We look forward to seeing the impact this role has on the structure, routine and purpose for the individuals who are residing there.

The physical environment

The layout of both Garry and Tummel Wards were the same, with individuals having single en-suite rooms. We noted the effort made in both wards to provide a dementia-friendly environment. We found the artwork and the use of colours and light contributed to a welcoming, bright, and warm environment not only for the individuals in the ward but for visiting family, relatives and staff.

We saw good use of photos and other objects that were reminiscent and familiar with individuals of all age groups on each ward. We heard of plans to improve the décor of Garry Ward, with plans for beach theme artwork on the corridor walls. The side room doors in Tummel Ward had recently been painted in different colours and we saw a completed art project funded by the Tayside Health Fund, showing a nature walk feature that had been applied along the corridor walls.

At our last visit, we had heard that the shared garden area was to be redesigned, and we were pleased to see this area provided an excellent example of a purpose-built

dementia-friendly garden. The area was shared by both Garry and Tummel Wards, was well maintained and included easy to read signage throughout the garden; this focused on encouraging individuals to engage in sensory experiences and mild exercise. We were told the individuals from both wards use this area often and can participate in light gardening or choose to relax in this enclosed, therapeutic space.

Summary of recommendations

Recommendation 1:
Managers should ensure nursing staff document clinical descriptions of an individual's presentation in care records.

Recommendation 2:
Managers for Tummel Ward should ensure the activities offered are documented in the individual's case notes and whether they chose to participate or not.

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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