Mental Welfare Commission for Scotland

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

Date of visit: 20 May 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

Leven Ward is a 14-bedded, mixed-sex, functional admission ward for older adults, over the age of 65. On the day of our visit, there were 13 people on the ward and one vacant bed. Two individuals were delayed from being discharged from the ward as they were awaiting a private guardianship application and suitable housing.

Leven Ward provides care for individuals primarily from the Perth and Kinross area.

We last visited this service in May 2024 on an announced visit and made recommendations that individuals and relatives were involved in developing care plans where possible, that each individual's participation should be documented in care records and they should be offered a copy of care plans. Where individuals chose not to or could not be involved, this should be recorded. Where a welfare proxy was in place, with powers to decide about an individual's treatment, they should be consulted and consent sought. The NHS Tayside 'locked door in mental health settings' protocol should be explained to individuals who are admitted informally to the ward and they should be informed of the procedure for accessing and leaving the ward when the door is locked.

On the day of this visit, we wanted to follow up on the previous recommendations, meet individuals, relatives/carers and staff to hear their views and experiences on how care and treatment was being provided on the ward.

Who we met with

We met with eight people and reviewed the care records of five of them. We also had contact with one relative.

We spoke with the service manager (SM), senior charge nurse (SCN), nursing staff, activity support worker (ASW), housekeeping staff and the consultant psychiatrist.

Commission visitors

Sandra Rae, social work officer

Susan Tait, nursing officer

What people told us and what we found

The individuals we met with on the day of the visit were positive about their care, support and treatment in Leven Ward. We were told all staff were “excellent”, “first class”, “kind”, “very good”, and that “I would not be here without this group of staff”, “they look after us, nothing is too much bother, but you know there are rules that need to be kept for your safety ”, and “they’re good at supporting us to attend the groups in the ward”.

All the individuals we spoke with said the “food is excellent”, “there are plenty of activities to do” and “the cleaners do a great job, they are conscientious, and the place is immaculate”.

Those that we spoke with were aware of their care plan and told us they had been involved in the completion of it. We also heard from individuals that they met with their consultant psychiatrist and all members of the multidisciplinary team (MDT) regularly, that they felt listened to and included in decisions regarding their care, treatment and support.

One individual told us that they did not always agree with the decisions made by the MDT however, their consultant psychiatrist took time to meet with them to explain why these decisions had been made which helped them better understand the reasons.

We heard that staff were available to meet individuals needs when requested. We heard from a relative who felt that the care given to their family member was excellent, saying “they all treated her with compassion and love, in spite of the lack of response from her, and sometimes "challenging" behaviour”. A relative told us that the staff had regularly checked on them and their mental state, recognising the stress they were experiencing due to their partner’s illness. A relative also told us that they “could not praise the care and professionalism enough”.

We heard from staff that the ward was “a nurturing place to work and learn” and that the whole MDT and housekeeping staff worked together with the same goal, which was to improve the care, treatment and experience for those in Leven Ward.

Care, treatment, support, and participation

Care records

Information on individuals care and treatment was held electronically on the EMIS system.

We found admission assessments were comprehensive and they included a physical health check. This gave the reader a good insight into the individual and their needs; this linked with care plans, risk assessments and risk management plans. We found these to be thorough, reviewed regularly and that they did link with care plans. The

information in the plans was person-centred, evidenced a strengths-based approach and had a focus on recovery to support discharge.

We found that the MDT were fully involved in the care and treatment plans, which supported a holistic approach to care. This information was reflected in care plans and promoted each individual's participation. We were pleased to see that a previous recommendation of involving the person and relevant others in care plans had been completed.

We saw that where appropriate, relatives/carers had input into care and treatment plans, providing information and their views. We were told there was a monthly care plan audit and action plans were shared with the team, promoting improvement.

We found one-to-one discussions between the named nurses and individuals were meaningful, detailed and were carried out regularly. An individual we spoke with told us "the staff are available to talk with anytime I want".

The reviews that had been completed were comprehensive and provided an evaluation of the individual's progress. Many of the reviews included input from all members of the MDT. We saw care and treatment plans being adjusted following reviews, to support any areas of progress or elements of increased support needed.

The risk assessments we reviewed were of a very high standard. The care records had various personalised risks assessments that supported the person in the ward and where appropriate, in the community. The level of detail in the risk assessments was robust and included identified risks, a detailed risk management plan and a safety plan.

We would have liked to have seen more evidence of that recorded the rationale for enhanced observation. We discussed this during our visit and were advised that this will be added when required. However, there was a good level of detail in care records of the as required enhanced support given to people that ensured the individuals' and others safety.

Multidisciplinary team (MDT)
A range of professionals were involved in the provision of care and treatment of individuals in the ward. This included psychiatry, psychology, junior doctors, all grades of nursing staff, an occupational therapist, (OT), physiotherapy, pharmacy, a transitional care nurse (TCN), an activity support worker (ASW), mental health officers (MHOs) and social workers (SWs).

We reviewed MDT meeting records and found a consistent approach in recording details from the weekly meetings, with reference to previous meetings and progress made or changes required.

The meeting template guided discussion in key areas, such as admission, legislation, risk, medication, diagnosis, physical health, time off the ward and family/carer perspective. We found the views of individuals recorded in the MDT proforma which was updated at each meeting. We noted that these were completed by the individual's named nurse, associate nurses, medical staff and the wider MDT.

There was a clear focus on consulting with families and we were pleased to find that there was a good level of communication recorded in the MDT proforma, which also included input from others in relation to discharge planning.

We asked about the two individuals whose discharges had been delayed. We were told that although this was discussed at MDT, there were challenges with the provision of suitable accommodation for individuals to move on to when ready for discharge. Another barrier was the timeframes for welfare guardianship applications for people who were admitted to the ward and who were deemed to lack capacity, which could cause longer delays.

Use of mental health and incapacity legislation

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

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. On reviewing the records, we found the electronic medications kardex records were stored on the hospital electronic prescribing and medicines administration (HEPMA) system. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

We were informed that there were regular audits of T2 and T3 certificates by pharmacy.

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 was in order.

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 were keen to review section 47 certificates as this had been a recommendation from the previous visit in 2024. We found the legal proxy/ decision maker had always been consulted in

relation to section 47 certificates, where relevant. We were told that monthly audits of section 47 certificates took place.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had not nominated a named person, we were told ward staff, MHOs and advocacy encouraged individuals to appoint one and promoted the importance and benefits of this. There was one person on the ward who had nominated a named person. We understand that sometimes people are too unwell and not able to fully consider this, but we were told that this is revisited when people's mental state improves and they are preparing for discharge.

Rights and restrictions

There was a locked door policy in place at Leven Ward to provide a safe environment and support the personal safety of the individuals. We were pleased to see that a previous recommendation relating to the locked door policy had been actioned. We saw evidence in the ward and in each person's room advising that a locked door policy being in place.

While this could have been proportionate for those who were detained, for those individuals who were admitted to the ward informally, we noted that there was an agreed plan on whether they had time off the ward or not. One individual we met with told us "it would be too big a risk me leaving the ward by myself due to my low mood and thoughts of suicide". For individuals who were admitted to the ward informally and did not need the door locked, we saw evidence of robust timeout plans, which had been agreed by the person.

We were told the locked door protocol was reviewed on an ongoing basis and we saw evidence of discussions with those who were informal being advised of their rights and the safety reasons for the door being locked, which was then recorded in the individual's care records.

When we were reviewing care records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We were told staff encouraged individuals to have an advance statement by promoting them during the individual's recovery and discharge planning. Reminders were also included in the ward discharge checklist document and community mental health teams were encouraged to follow them up with individuals following discharge. However, despite these efforts, we only found one advance statement on file.

We were told advocacy visited all individuals in the ward, and access was available by self-referral or by ward staff identifying a need and then encouraging and supporting the individual to arrange contact with them.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

Leven Ward had input from a designated ASW who devised a weekly activity timetable, which included input from individuals to identify and focus on their preferences and interests.

The activity planner included a wide range of activity options such as crochet, yoga, social group, visits by a therapet, music quizzes, table tennis, hairdressing and gardening. We were pleased to see that not all activities took place on the ward, and on the day of our visit, individuals had left the ward to go for a coffee in the grounds.

OT staff also provided individualised, focused, structured and therapeutic activities that promoted and taught skills that were transferable to outside living. These included using the activities of daily living kitchen, as well as having a focus on improving the physical health of individuals with seated and strengthening exercises.

The staff we spoke with were complimentary and positive about the activity and occupation available on the ward. We were pleased to hear positive comments from staff who lead the activities who informed us, “there’s great respect for each profession”, “staff are always open to ensure activities that include each person are available”.

We were pleased to see person-centred activity care plans that were regularly reviewed and updated.

The physical environment

In Leven Ward, each person had their own ensuite bedroom which could be personalised at the individuals or relatives’ request. The ward was welcoming, bright and airy with lots of tactile interactive tools placed throughout and had well-kept garden areas that encouraged interactivity; we were able to observe the visitors and individuals using the garden throughout our visit.

The ward areas and bedrooms were immaculate. We heard from relatives and people on the ward that they found the level of cleanliness to have a positive therapeutic effect on their wellbeing.

---

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Leven Ward was a therapeutic and calming environment for individuals. We were pleased to see clear and easy-to-read signage throughout the ward, encouraging people to take some gentle exercises during their stay.

We were told NHS Tayside anti-ligature works had yet to commence in Leven Ward, but that the programme was underway with the ward awaiting a date for the work to begin. Leven Ward has continued to mitigate risks and had increased use of floor nurses, continued risk assessment that included the use of the 'Manchester clinical risk in mental health services' assessment tool and staff training on ligature and suicide awareness.

Summary of recommendations

The Commission made no recommendations from this visit.

We would like to receive information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. We will follow up with the service to obtain this information.

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