Mental Welfare Commission for Scotland

Report on unannounced visit to:
Murray Royal Hospital, Garry Ward, 4 Tom Macdonald Avenue, Muirhall Road, Perth PH2 7BH

Date of visit: 21 January 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

Garry is a 12-bedded, mixed-sex ward based in Murray Royal Hospital. The ward provides assessment and treatment for older adults with dementia in the Tayside area.

On the day of our visit, there were seven people on the ward and five vacant beds.

We last visited this service in July 2024 on an announced visit and made recommendations that nursing staff document clinical descriptions of each individual's presentation in care records.

The response we received from the service was the multidisciplinary team (MDT) had communicated to all staff the importance of documenting clinical descriptions in care records and were offered support when required. All staff attended record keeping sessions and stress/distress training to increase their understanding of documentation in relation to the physical and psychological presentation associated with illness and that record keeping was audited on a monthly basis.

On the day of this visit, we wanted to follow up on the previous recommendation and speak with the individuals receiving care and treatment in Garry Ward and their carers.

Who we met with

We met with six people and reviewed the care records of two of them. We also met with four relatives.

We spoke with the senior charge nurse, the charge nurse, nurses and the activity support worker (ASW).

Commission visitors

Gordon McNelis, nursing officer

Audrey Graham, social work officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

Most individuals that we met with gave generally positive comments about staff and the ward. We were told that “staff are good”, “if you want help, you’ll get it here” and “I like all activities”. We also heard some different views where individuals told us that “it gets very boring” and “I like walking but don’t get out to walk here”.

Relatives gave complimentary feedback about staff and the ward, with staff described as “excellent”, “supportive” and providing “superb care”. We heard that staff kept relatives updated with information and some told us that the staff were welcoming and they could visit the ward as often as they liked. One relative told us “we want the best for dad and here we’ve got it”. However, we also heard some contrasting views from relatives, including feedback regarding a lack of consultation with carers.

We heard from ward staff that “we’re a really good team” and “I love my job here; it’s very rewarding and good to know you’re making a difference”.

During our visit we observed that all individuals looked very well cared for and noted they had a good standard of personal care and grooming. We saw individuals engaging comfortably with staff, including communicating through gentle touch-based interaction.

Care, treatment, support, and participation

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

During our review of care plans, we found variable quality. Some included comprehensive information, while others were brief and lacked detail. We also noted a disconnect between the identified need, goal and intervention, as these did not consistently match the action of the care need.

We discussed the quality of the care plans with senior staff at our end of visit meeting and advised that care plans should meet the standards in the NHS Tayside person-centred care planning format.

During our review of the continuation records, we found these included detailed content and a range of professionals contributed to the records. We wanted to follow up on our previous recommendation regarding nursing staff documenting clinical descriptions of an individual’s presentation in care records. We were pleased to find detailed clinical descriptions that captured the individual’s presentation and focussed on the essential care and treatment delivered.

Although we found evidence of one-to-one discussions taking place between individuals and staff, the content and frequency of these varied. We acknowledge

that communication between staff and the individual may have limitations due to the progression of their illness, however, we would have expected the positive use of tactile engagement that we observed between ward staff and the individuals to be documented in the continuation notes, reflecting these interactions.

Risk assessments were easily found, although at the time of the visit we asked about the availability of guidance and direction for staff in relation to risk management plans. We discussed this with senior staff at the end of our visit and have since been advised that this is located in the NHS Tayside Mental Health & Learning Disability Nursing Standards for Person Centred Care Planning.

Recommendation 1:
Managers should ensure risk management plans are robust in order to manage identified risks, referring to the standard in the NHS Tayside person centred care planning document.

We saw do not attempt cardiopulmonary resuscitation (DNACPR) advance decision information displayed on the information board in the nurse's office and also included in MORSE. Although we saw DNACPR reviews and information communicated to staff, we did not find whether the carer/proxy decision maker had been consulted and made aware of a decision.

The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf). This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR.

Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the individual. In all cases, this involvement or consultation should be recorded.

Recommendation 2:
Managers must ensure that open and honest communication with relevant others regarding the decisions to attempt or not attempt CPR takes place and that these discussions are documented in care the records.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Multidisciplinary team (MDT)
The MDT for Garry Ward consisted of psychiatry, nursing staff and an ASW.

The ward also received input from occupational therapy (OT), a transitional care nurse, the hospital discharge team, including a social worker, physiotherapy, pharmacy, and community psychiatric nurses (CPNs) and community based mental health officers (MHOs).

We reviewed the MDT meeting records and found these had a record of those in attendance, discharge planning information, updates on changes in each individual's mental state since the last meeting and recorded actions. We found the individuals' and carers views were recorded and captured along with subsequent discussions and clear action points where necessary.

Garry Ward offered carers the opportunity to participate in family meetings and discharge planning meetings; carers told us they were satisfied with the support and sharing of information, however a common theme we heard was their preference for increased consultation with the responsible medical officer (RMO) throughout their relatives' inpatient care.

We raised the carers views with senior staff to make them aware of this and for them to consider increased opportunities for consultations with carers.

We found MDT discussions were also documented separately in the continuation notes which included updates and the actions to be taken. There appeared to be no reason for the duplication of this information.

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) and six people were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

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. During our review of this information, we saw one individual had a certificate authorising treatment (T3) under the Mental Health Act in place which corresponded to the medication being prescribed.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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.

On reviewing individuals' records, although all documentation relating to Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment were found, they were not well organised. A significant number of these were either older copies or not consistent with the corresponding printed and electronic versions. We requested that the most up to date copy of a compulsory treatment order (CTO) certificate was printed and stored in the relevant folder in the ward, and that a short term detention order certificate (STDC) was uploaded to MORSE.

We also requested five section 47 certificates were printed and stored in the relevant folder on the ward and five copies that were stored on MORSE were replaced with the most up to date copy.

For individuals who had covert medication in place, we found the covert medication care pathway forms complete and in good order. These included input from relatives, the consultant psychiatrist, along with clear guidance and instruction from pharmacy. However, the storage of the forms was disorganised with some copies only accessible in print while others were only available in online formats.

The issues regarding the disorganisation and inconsistency of all legal files were raised with senior staff at the end of day feedback meeting. We advised that the storage of both printed and online versions on MORSE must be organised to include current versions and for both formats to consistently correspond with each other.

We noted there was an unnamed folder that contained some legal documents however, not all individuals had their documentation included and there was no clear structure for storing documents. We advised that this folder should be clearly named and organised to ensure printed copies of all legal documents were included for all individuals. We would expect this folder to be regularly reviewed and audited. The senior staff group advised they intended to follow up and address our findings.

Recommendation 3:
Managers must ensure legal documents held in paper and electronic form are current, organised and both formats consistently correspond with each other.

Rights and restrictions

A locked door policy remained in place for Garry Ward 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 those in the ward.

We saw appropriate use of QR code signage advising people of the locked door policy restrictions in place. The locked door policy was explained to individuals and their carers as part of the admission criteria, and we found evidence of these discussions taking place in care records.

Garry Ward had good support from advocacy services, who had a visible presence on the ward and who were available to the individuals and carers.

Activity and occupation

Garry Ward had input from a dedicated ASW who provided a variety of activities for individuals. We were told that both person-centred, one-to-one and group activities were available, which included arts and crafts and jewellery making sessions, playing carpet bowls, darts and tennis, plus focus on exercise that included yoga, seated exercise and dancing.

Doll therapy intervention was also available for the individuals to provide comfort, connection, a sense of purpose and act as a form of communication.

Activities could take place in the ward activity room which had direct access to a shared garden area where individuals could participate in gardening and flower arranging.

We heard positive feedback from individuals and carers about the activities that took place on the ward and in the local area, hearing “I like playing bowls, it’s one of my favourites”, “he has been taken to the bowling green in town and loved it”, “I like making jewellery and the diamond art” and “I like going to the hub for a cup of tea”.

During our review of the activity records, we saw good use of the ‘getting to know me’ document that included the individuals likes and dislikes, with contributions from carers.

The physical environment

The ward featured colourful murals and meaningful traditional pictures which helped create a calm, dementia friendly environment.

The layout of the ward consisted of single ensuite bedrooms that were clean and well kept. Bedroom doors were personalised and included the individuals’ names and pictures from their memory box to support orientation in the ward.

The ward had access to a shared dementia-friendly garden which was frequently used, well maintained and included randomly placed prompts to encourage individuals to participate in mild exercise.

Individuals could be supported to access a therapy kitchen, which was facilitated by both OT and the ASW.

Summary of recommendations

Recommendation 1:
Managers should ensure risk management plans are robust in order to manage identified risks, referring to the standard in the NHS Tayside person centred care planning document.

Recommendation 2:
Managers must ensure that open and honest communication with relevant others regarding the decisions to attempt or not attempt CPR takes place and that these discussions are documented in care the records.

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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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