Mental Welfare Commission for Scotland

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

Date of visit: 31 October 2019

Where we visited

Amulree is a 16-bedded rehabilitation ward caring for male and female patients. On the day of the visit the ward was fully occupied. The ward recently merged from two rehabilitation wards into one ward.

We last visited this service on 27 January 2017 and made a recommendation in relation to a protocol for the low stimulus room (which is no longer in use) and discharge planning.

On the day of this visit we wanted to meet with patients and staff, and to follow up on the previous recommendation. We also wanted to look at the reconfiguration of the ward following the merger of the two rehabilitation wards which has happened since our last visit.

Who we met with

We met with and/or reviewed the care and treatment of eight patients.

We spoke with the interim head of service, a charge nurse, one of the medical staff, and with other nursing staff.

Commission visitors

Moira Healy, Social Work Officer

Claire Lamza, Nursing Officer

Philip Grieve, Nursing Officer (secondee)

What people told us and what we found

Care, treatment, support and participation

On the day of the visit we were welcomed onto the ward which maintained a calm atmosphere throughout the day. Staff were observed to be engaging with patients and were clearly enthusiastic about their work.

All patients we met spoke highly of nursing staff and said they were friendly and always available to help and listen when needed.

Since our last visit, the ward has merged with another rehabilitation ward to form one mixed ward. Following our last visit, a number of patients who were delayed discharges at that time have now moved on to community placements. There were no delayed discharges on the day of this visit.

Electronic patient records were well organised and it was easy to locate most of the information we were looking for. There is a holistic mental health assessment in every patients file. This gave an overview of the patient in terms of personal background and support network, the presenting complaint and the mental health assessment, the mental health treatment history and patients physical and functional status.

Risk assessment and management plans were present for all patients whose files we reviewed and formed the basis of care plans, most of which were well written. However, there were concerns that, although the care plans were well written, they appeared to have been written with little recognition of patient involvement. For this group of patients we consider it important that it is evidenced that patients are fully involved in care planning, setting and reviewing goals. Some care plans were not dated and therefore it was difficult to assess progress.

The review process was inconsistent and whilst we saw some reviews which were detailed and updated regularly, this was not always happening. In addition, they did not always take into account where there were changes and improvements for the patient in relation to their needs, goals and interventions. As the original care plan sometimes had no date, it was difficult to see if the goals had changed and if so when.

The Commission has published a good practice guide on care plans. 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, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Recommendation 1:

Managers should ensure that patients participate in care planning and care plans are audited on a regular basis.

Multidisciplinary Team (MDT) working

The current consultant psychiatrist is a locum with no specialist training in rehabilitation.

The ward has one whole time psychologist and one part time psychologist. Patients who were involved with a psychologist were positive about their experiences which included family based therapy.

There is regular pharmacy input to the ward including audit of medication use in line with the Scottish Patient Safety Programme.

The ward has one whole time equivalent Occupational Therapist (OT) and 1.5 whole -time equivalent OT technician. There is an art therapist employed for 17 hours per week.

There is an MDT meeting once a week. The clinical discussions are well-documented in the notes. However, there was not an attendance list so it was difficult to identify if the patient and which members of staff attended.

Recommendation 2:

Managers should ensure that there is a record of attendance and contribution for all MDT meetings.

Throughout, the daily progress notes there was evidence of one-to-one sessions with nursing staff but this was often documented as a descriptive record of how the patient was on that day rather than a reflection of dedicated therapeutic one-to-one time. The recording of one-to one-time in daily progress notes is an important component of therapeutic involvement and should be recorded as such.

Mental Health and Incapacity legislation

Part 16 (s235-248) of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required.

We discussed with staff a complex case involving fluctuating capacity to consent and how this should be managed.

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future.

Only one patient had an advance statement. We discussed with staff that it would be helpful to discuss the use of advance statements for all patients in Amulree Ward, and we would encourage staff to promote awareness of advance statements. The commission has some useful resources about advance statements and these can be found on our website at:

https://www.mwcscot.org.uk/media/128044/advance_statement_guidance.pdf

Rights and restrictions

Specified persons

Section 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in

relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied

On the day of the visit we had difficulty locating appropriate specified person documentation for some patients. In addition, the information on the whiteboard in the nurse's office in relation to specified persons was sometimes incorrect as it was out of date. This caused some confusion in relation to individual patient's status.

Our specified persons good practice guidance is available on our website.

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

Recommendation 3:
Managers should review current processes in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

The ward is unlocked for most of the day except for short periods of increased clinical activity and patients can ask a member of staff to unlock the door if they wish to leave the ward during these times. We discussed with the team some of the new practices they are implementing in individualised interventions, through the SPSP-Improving Observation Practice guidance and this should eliminate the requirement to lock the ward door during the day.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

The ward has one whole time equivalent occupational therapist (OT) and 1.5 whole time equivalent OT technician. Patients we met with, and reviewed the care of, were engaged in a wide variety of activities which included swimming, budgeting, cooking, out for walks with staff, passes home, charity work, attending local community projects in addition to the activities available on the ward. However this was not recorded in the daily progress notes in a systematic way and we did not find any activity timetable along with the care plan. We were advised that activity timetables are often held by patients in their own rooms.

We thought it would be helpful to have an activity timetable held within the notes as it would provide the framework to see exactly what activities patients are engaged in.

The physical environment

Amulree Ward is a spacious ward with a range of areas to participate in activities. All patients' rooms have en suite facilities.

There were day areas with and without TVs, and we saw patients engaging in games/activities in their communal area on the day of the visit. There were also opportunities to play table tennis, pool and use exercise machines. There is also a proposal to use one of the smaller sitting-rooms as a sensory or Snoozelum room which has been taken forward by one of the charge nurses.

It was good to see a focus on physical wellbeing. There is a poster identifying how much sugar is in various drinks and items of food, there is a step challenge to see how many steps people had taken during the week and there was another poster to identify how much money you could save if you gave up smoking.

In addition to this, there is also the OT activity programme on a wall that identified what was happening from Monday to Friday; however this was not at weekends and there should be an expectation that patients will remain engaged in activities on a Saturday and Sunday.

On one wall outside the nurses' room, there was also a list of staff who would be on duty across all shifts on the day. There were drawn images of trees, for example POSITVI-TREE which focussed on recovering messages from all patients and the AMUL-TREE which has messages and information about the staff.

There was a separate board signposting what was available for patients in terms of support which details where there were meetings and resources. There was a range of pamphlets and leaflets around the ward giving advice about mental health and support that was easily accessible all from the main entrance of the ward.

There is a well-established spacious garden that is secure and was used throughout the day by patients, as well as a small courtyard garden which was used by patients on the day. We were advised that there are plans to develop the garden area with plots for growing plans and vegetables.

Patient rooms were en suite, spacious, and modern and there was an opportunity to personalise these with their own items. There is a locked drawer for patients to keep their personal items securely. However, there were no rooms that had been adapted for semi-independent living and the kitchen was small compared to the number of patients on the ward who we expected would have been involved in budgeting and cooking.

Recommendation 4:

Managers should review the current ward layout and consider adapting some rooms for more independent living and extending the current kitchen to include opportunities for all patients.

Summary of recommendations

1. Managers should ensure that patients participate in care planning and care plans are audited on a regular basis.

2. Managers should ensure that there is a record of attendance and contribution for all MDT meetings.

3. Managers should review current processes in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

4. Managers should review the current ward layout and consider adapting some rooms for more independent living and extending the current kitchen to include opportunities for all patients.

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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