Mental Welfare Commission for Scotland

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

Date of visit: 27 November 2019

Where we visited

Moredun Ward is a 22-bedded mixed-sex adult acute admission ward. All rooms in the ward are single and en-suite, with male and female patients in rooms at different sides of the ward. There are enclosed gardens around the ward.

We last visited this service on 13 February 2019, when we made a recommendation about care planning. We received a clear action plan in relation to this recommendation, which described the improvement actions the service was taking to develop the approach to care planning in the ward.

On the day of this visit we wanted to meet with patients, look generally at how care and treatment is being provided, and to follow up on the previous recommendation.

Who we met with

We met with and/or reviewed the care and treatment of 11 patients, and spoke to one relative.

We spoke with the senior charge nurse, the nurse manager, and with the consultant psychiatrist responsible for care and treatment in the ward. We also met and spoke with a number of members of the nursing team during the day.

Commission visitors

Ian Cairns, Social Work Officer

Alison Thomson, Executive Director (Nursing)

Philip Grieve, Nursing Officer

Dr Juliet Brock, Medical 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 Moredun Ward and about their interaction with staff. Some patients did not feel they were unwell, or that they needed to be in hospital, and they tended to be less positive about the support they were receiving. One patient who had recently been admitted to the ward told us they had been given good information about the ward when they first came in, with staff spending time orientating them to the ward, and we heard other comments about staff being available when patients needed to talk and needed one-to-one support. Several patients spoke about how nurses talked to them about their care plans and indicated that they had copies of their plans, although we did hear from other patients that they were not aware of what was recorded in their care plans.

Several patients who were subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') also said that they could not remember having been told about or given information about their rights as detained patients. In one case where we reviewed the detention paperwork it was clearly recorded in the certificate that information had been given but it can be the case that when a patient is very unwell they don't retain information they are given about their rights. The Commission would encourage staff on the ward to check with patients on an ongoing basis if they are aware of their rights and to provide information about these rights regularly.

We met one relative whose family member had been an inpatient in the ward until very recently. This relative wanted to come back into the ward to speak to Commission visitors to let us know that they had been very pleased with all the care and support provided by staff in the ward over a lengthy period. They felt that all staff, including cleaners, healthcare assistants, nurses and doctors, had been supportive and helpful. The relative had been visiting the ward on a very regular basis and thought that staff were very professional and were also very caring and compassionate, and they said that their observation was that staff interactions with all patients were very positive. Specifically with regard to their relatives, they said staff gave family members a lot of support, taking time to explain things, and providing support and reassurance which helped alleviate family members' stress and concerns.

Care planning documentation

Commission visitors reviewed the records for a significant number of patients in Moredun Ward on the day of the visit. We found holistic mental health assessments in place in a number of files reviewed and, when this document had been completed, it provided clear and detailed information about the individual person, giving a good picture of current and past mental health problems and of a person's strengths and identified needs. We did not see these holistic assessments in place in all files and we feel that it would be good practice for these assessments to be completed for every patient as they will be very helpful guiding nurses working with patients to create person centred care plans to meet identified needs.

With regard to care plans, the format used has a straightforward and clear layout. We noted that the care plans were variable. Some plans we saw were very detailed, with good information recorded about specific interventions relating to specific needs which had been

identified. As mentioned above we also heard from several patients that they did feel that they had been involved in the process of developing their care plan, with a few patients telling us they had copies of their plans. A number of plans we saw though were less detailed and person-centred, with limited information about actual interventions and how these related to assessed needs.

The Commission is aware that there is ongoing work in the service, focussing on developing a person-centred approach to care planning. We know that NHS Tayside has recently produced standards for person-centred care planning and that all registered nurses within Moredun have had one-to-one training sessions on these standards. We also know that peer reviews and the audits of care plans are taking place. The Commission is pleased to see this focus on care planning and we would expect this to address inconsistencies in the quality of care plans as new standards are embedded in practice.

Care and treatment provided in the ward is now reviewed in rapid rundown meetings which are held daily on Monday, Wednesdays and Fridays, and which have replaced the weekly multidisciplinary (MDT) meetings. We heard that this new procedure helps ensure that decision making is quicker if an individual patient's needs change with consequent changes having to be made to the care and treatment being provided. We saw records of these rapid rundown meetings in individual files and saw that the information recorded was often very brief but that any agreed actions were clearly identified. It was not clear from the files how patients were involved in decisions made at these rapid rundown meetings and this was discussed at the end of the visit. While patients do not routinely attend these rapid rundown meetings we heard how their views will be considered and how decisions will be fed back to individual patients after meetings. The Commission thinks it is important that patients are fully involved in decisions about their care and treatment, and it is one of the fundamental principles in the Mental Health Act that the patient participates as fully as possible in their care and treatment.

We would encourage the unit to keep the issue of patient involvement in the rapid rundown meeting process under review. We also heard on the visit that, as well as the rapid rundown meetings, separate MDT meetings will be held in relation to specific patients. If a patient has complex needs these can be reviewed within the care programme approach (CPA) framework (a framework which can be used to assess needs and improve the co-ordination of care when someone is receiving care and support from a range of different professionals). We heard that patients and family members will be involved in CPA meetings and that MDT meetings will be arranged at the point when discharge is being considered and discharge plans are starting to be prepared, with family and patient input into these discharge planning meetings.

The ward should have dedicated clinical psychology input, with 0.5 of a psychology post attached to the ward. Unfortunately this post is currently vacant but it is hoped that this can be filled in the near future. In the meantime though, referrals can be made to the psychology service and we met one patient on the visit who had only recently been admitted to the ward but had already had an appointment with the psychology service because of an identified need for specific psychological therapy input.

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

Use of mental health and incapacity legislation

The majority of patients in the ward on the day of our visit were detained under the Mental Health Act, and paperwork was well maintained and easy to access within files.

Part 16 (s235-248) of 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. We examined the drug prescription sheets and treatment certificates which should be in place to authorise medication when a patient is detained and when medication has been prescribed on a compulsory basis for more than two months. A consent to treatment (T2) or certificate authorising treatment (T3) form requires to be in place to authorise medication prescribed in these circumstances. This review identified several issues about the authorisation of medication.

In some files copies of T2/T3 certificates were not readily available or filed with the patient's prescription sheets. We found a number of patients whose prescribed medication was not authorised by T2 or T3 forms. We saw that one patient, who was acutely unwell, had a significant amount of medication authorised on a T2 form and, given their clinical presentation, we queried their capacity to consent to their current treatment. We noted that one patient had a T2 form including as required medication to be administered intra-muscularly (IM) for agitation. Our view is that a patient is very unlikely to be consenting to IM medication for agitation at the time this is felt to be urgently necessary. We also saw that several patients were prescribed high doses of antipsychotic medication, exceeding British National Formulary (BNF) maximum doses. *Wi*th some patients it may be appropriate to raise the dose of an antipsychotic drug above that which is normally recommended but this should be accompanied by appropriate safety monitoring. A number of patients we reviewed had been identified by the pharmacist as receiving high dose antipsychotics but the necessary monitoring had not been completed.

All the above issues were discussed on the day with the lead consultant, and we also spoke to the consultant and the ward pharmacist about polypharmacy (the prescription of multiple medications), and about the use of haloperidol medication on an as required basis, and we were advised that local guidelines were being updated.

Recommendation 1:

Managers should ensure that regular audits of prescribing and high dose monitoring arrangements are carried out.

Recommendation 2:

Managers should ensure consent to treatment documentation is audited to ensure that treatment is legally authorised.

Rights and restrictions

Work is currently ongoing in NHS Tayside focussing on developing a least restrictive practice approach to observation in line with the new guidance published in January 2019 by Healthcare Improvement Scotland, "From observation to intervention". This approach is being rolled out across all the adult admission wards, including Moredun Ward.

As mentioned above in the section on comments from patients, a few patients who were subject to compulsory measures under the Mental Health Act did not seem to be fully aware of their rights. As we have said above, someone who is acutely unwell may not remember information they have been given about their rights and it may be that staff need to provide this information on an ongoing basis to some patients. We also noted on the day of the visit that the door into the ward was locked and this is the case very frequently in Moredun. Patients we met on the day who were informal patients did say that they knew they could go out of the ward when they wanted to. It is important when people are not subject to compulsory measures under the Mental Health Act that they do understand that they can leave the ward even when the door is locked and we would expect all patients who are informal patients to be aware of this.

Several patients told us how they were accessing support from the local independent advocacy service and there seems to be good input from this service into the ward.

Sections 281-286 of the Mental Health Act provide a framework where restrictions can be placed on people who are detained in the hospital. Where a patient is a specific person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of lease restriction is applied. We did see that patients who were specified persons had appropriate Mental Health Act paperwork in place. In one file reviewed we saw that the patient had been a specified person but that specific restrictions had now been removed. In this file we saw that a care plan had been prepared in relation to the specific restrictions applied, with this care plan being revoked as soon as the restrictions no longer applied. This is good practice and is what the Commission would expect to see in place, and indicates that decisions to make a patient a specified person are being reviewed. However we did not see a specific care plan in place in relation to patients who were currently specified, although when we spoke to nursing staff in the ward they were aware of the specific restrictions in place for these patients.

Recommendation 3:

Managers should ensure when a patient is a specified person in relation to Sections 281-286 of the Mental Health Act that a care plan is in place which sets out the specific restrictions which are in place.

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/visits-investigations/local-visit-reports.

Activity and occupation

On the day of the visit we saw staff spending time with individual patients and we saw patients who were engaged in meaningful activities. A range of activities are available within the ward, including pottery, arts and crafts, cooking and baking, and activities which focus on physical exercise. We did hear comments from patients who said that they were not interested in the activities available and that they preferred to spend time in their own room. We also felt that, while patients are encouraged to engage in meaningful activities, the evidence in files of patients participating in activities is limited. We think that more activity work is being undertaken in the ward than was reflected in files. Several patients did also tell us that they knew that activities were available but that they did not feel well enough at present to engage in these activities. One patient also said to us that some of the equipment available for recreational activities needed to be renewed and that they thought that some equipment had been stored away at a point when Moredun Ward expected to transfer from Murray Royal Hospital to the Carseview Centre. We feel it would be helpful to review activity provision in the ward with patients, to look at how provision can be developed.

Recommendation 4:

Managers should review the provision of structured activities within the ward, involving patients in this process and review how patient engagement is recorded.

The physical environment

Patients can access enclosed gardens easily from the ward.

The design and layout of the ward has been discussed in previous reports and it is acknowledged that staff have difficulty maintaining observation given the distance of some bedrooms from the main hub of the ward. The Commission has previously been informed that staffing levels have been increased so that nurses on shift can go round regularly checking on individual patient needs and wellbeing, and on this visit we were told that increased staffing levels have been maintained.

New door-top alarms have recently been fed in to two bedroom doors, to ensure that staff can be more aware of where patients are within the ward. Door top alarms have been fitted on all bedroom doors, as part of the ligature reduction works.

Summary of recommendations

1. Managers should ensure that regular audits of prescribing and high dose monitoring arrangements are carried out.
2. Managers should ensure consent to treatment documentation is audited to ensure that treatment is legally authorised.
3. Managers should ensure when a patient is a specified person in relation to Sections 281-286 of the Mental Health Act that a care plan is in place which sets out the specific restrictions which are in place.
4. Managers should review the provision of structured activities within the ward, involving patients in this process and review how patient engagement is recorded.

Good practice

As mentioned earlier in this report there is ongoing work within the service to develop a person centred approach to care planning and also to implement the new HIS guidance on developing a least restrictive practice approach to observation. In addition we were told on the visit that a new care pathway has just been introduced, for patients with a diagnosis of emotionally unstable personality disorder. Someone who has this diagnosis can experience difficulties accessing appropriate care and treatment and the Mental Welfare Commission has recently published a visiting monitoring report, Living with Borderline Personality Disorder. (https://www.mwcscot.org.uk/sites/default/files/2019-06/nov2018bpd_report_final.pdf)
One of the recommendations in this report was that integrated care pathways should be developed within each health board and we were pleased to hear about publication of a recent pathway in NHS Tayside.

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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