Mental Welfare Commission for Scotland

Report on announced visit to:

Leven Ward, Murray Royal Hospital, Muirhall Road, Perth PH2 7BH

Date of visit: 20 March 2023

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Leven Ward was a 14-bedded, mixed sex functional admission ward for older adults. On the day of our visit, Leven ward had two vacant beds. We were told that the ethos of the ward was to use a multi-professional approach to ensure person-centred recovery focused care. We heard that the ward focus was on rehabilitation and empowerment that encouraged patients to maintain, improve and maximise their independence, skills and self-confidence. The view of the ward was that if self-esteem, problem solving abilities and motivation improves, this will lead to earlier recovery and discharge, therefore promoting health and reducing relapse.

We last visited this service on 5 September 2018, along with two other wards, and made recommendations regarding the auditing of care plans, authority to treat certificates and auditing the provision of activities.

During our visit we wanted to follow up on the previous recommendations and hear how patients, staff and relatives had managed throughout the Covid-19 pandemic.

Who we met with

During our visit we reviewed the care and treatment of three patients and we also met five relatives.

We spoke with the service manager, consultant psychiatrist, senior charge nurse and other members of the nursing team.

Commission visitors

Alyson Paterson, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with during our visit were very complimentary about the staff on Leven Ward. They were described as wonderful, cheery, approachable, kind and friendly. We heard that staff took the time to get to know the patients on the ward. One patient however was not sure who their named nurse was.

The relatives we spoke to were equally positive about staff and told us that staff were concerned not just about patients, but about the wider family also. Relatives told us that they had been linked in with a carer support worker who provided support and had arranged for a carer's assessment to be undertaken. We heard from relatives that treatment on the ward was superb and that they were very happy with the care their relative had received. We were told by relatives that the ward was well staffed. Relatives felt listened to and that information and suggestions they provided were acted upon. Relatives told us they felt part of the care team. Communication between the community health team and the ward was described as very good. We heard mostly that staff were available, responsive and gave regular updates. One relative however said that they always had to ask for updates and would prefer if they were just provided.

Many of the patients chose not to engage in a discussion about their care and treatment. However, we spent time on the ward, speaking to and observing patients. There was a calm atmosphere in the ward and we witnessed staff engaging with patients in a warm and supportive way.

From staff that we spoke with, we heard how challenging the last two years had been since the start of the Covid-19 pandemic, although we were pleased to hear that there had been a focus on staff wellbeing throughout the pandemic and this had continued. All staff had access to psychology for brief intervention sessions.

We heard about the work that was taking place in relation to anticipatory care planning (ACP) with a focus on involving patients and their families in drawing up an individualised ACP.

We heard that the activity support worker had recently trained in 'playlist for life', an evidence-based initiative to support people living with dementia to create a playlist of personally meaningful music, with the aim to reduce stress and distress. We look forward to hearing more about this on our next visit.

We were also pleased to hear about the development of a transitional care (TC) nurse who supported discharge planning. Patients were supported when they moved from hospital to long-term care for a transitional period, thereby bridging the gap between hospital and community mental health teams. The TC nurse had developed therapeutic care plans to support patients, and these accompanied patients to their long-term care placement. The TC nurse worked with all care homes across the Perth & Kinross area. As part of the TC role, the service had developed the 'This is ME' poster, which also accompanied the patient to their long-term care placement. The TC role was initially only funded for six months in December 2021, to support transition from hospital to care home. However it was acknowledged that this was a fundamental role in the service to support proactive and robust discharge planning.

Funding has since been secured until March 2023, with a view to making this role permanent for the Perth & Kinross older people's in-patient service. The benefits of the TC role had been demonstrated, as out of 100 complex discharges, only one patient has had to return to Leven ward**.** Additionally we heard about the development of weekly integrated meetings which focused specifically on discharge planning and delayed discharges.

Care records

Information on patients care and treatment was held mainly on the electronic patient record system, EMIS, along with a paper file. Although the system was relatively easy to navigate, some information was difficult to locate, for example the name of the patient's doctor or social work mental health officer (MHO). The daily continuation notes regarding patient care and treatment were descriptive, had little patient information and did not evidence specific interventions or outcomes. We read some case records that used negative language, describing the individual, for example, as 'misusing the buzzer'. We found this language to be unhelpful as it did not provide a clear explanation of the patient's behaviour or suggest supportive interventions.

We were unable to locate copies of power of attorney (PoA) and guardianship certificates in the records. It is important that this information is contained in care records as it gives legal authority for an individual to make certain decisions on behalf of someone else. We were told that all missing PoA/guardianship certificates had been requested.

Recommendation 1:

Managers should ensure that when a welfare proxy is in place for a patient, a copy of the document stating the powers of the proxy should be held within the case notes.

In one file we found a 'do not attempt cardiopulmonary resuscitation' (DNACPR) certificate. The certificate had not been discussed with the PoA. We were advised that this certificate had been completed pre-admission, however would be updated.

Care planning

Nursing care plans are a tool that identify detailed plans of nursing care and effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. NHS Tayside have produced a set of standards, *Mental Health Nursing: Standards for Person Centred Planning*.

We heard that care planning and treatment was delivered on Leven ward in an individualised and holistic manner and that care would be discussed and agreed with patients, as participation in recovery was being encouraged. Nursing interventions involved person-centred goals, maximising patient participation and involvement. Leven ward had an ethos of rehabilitation and empowerment that encouraged patients to maintain, improve and maximise their independence and skills, promoting self-confidence.

We were pleased to hear that to support the ongoing quality of care plans and documentation, monthly audits were undertaken by the charge nurse in Leven ward. Action plans were subsequently developed and fed back to nursing staff. We were told that patients and relatives were encouraged to participate in care planning.

During our visit, we reviewed care plans that were held on EMIS. We found them to be mostly person-centred and addressed a range of needs including mental and physical health needs and addressed social and cultural factors. Goals and interventions required to meet specific needs were evidenced. We were pleased to see rich information contained in one care plan rather than many. Although there was evidence of review, we would have expected to find detailed summative reviews that targeted nursing intervention and individual's progress to meet specific, person-centred goals.

In the care plans that we reviewed, we found inconsistent evidence of patient and relative involvement. Some relatives advised us that they had provided information which was included in their relatives care plan. However, many of the patients and relatives we spoke to had not been involved in care planning and did not have a copy of the care plan. Some relatives told us that they were aware of what the plan was. Where patients were unable to fully participate in care planning due to the progression of their illness, we would have expected this to be discussed and recorded.

The risk assessments we saw were comprehensive and of a good standard, showing appropriate interventions to manage risk. Risk management plans were clear and corresponded to risks identified.

Recommendation 2:
Managers should ensure that staff completing care plans undertake care plan training and refer to NHS Tayside's person-centred care planning standards.

Recommendation 3:
Managers should ensure that nursing staff include summative evaluations of care plans in patient notes that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 4:
Managers should ensure that patient/relative involvement in care planning is encouraged and recorded.

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/node/1203

Multidisciplinary team (MDT)

A range of professionals were involved in the provision of care and treatment in Leven ward. This included nursing staff, health care support workers, a consultant psychiatrist, a speciality/junior doctor, an activities support worker and a ward clerk. OT, pharmacy, physiotherapy, psychology and speech and language worked across the service and their involvement was dependent on individual patient care needs. Additionally there was an allocated social worker for Leven ward and a transitional care nurse who worked across a number of wards, supporting discharge planning and transitional care.

We were told that there were a number of vacant posts for nursing staff in Leven ward. We heard that the service regularly used bank and agency staff and that there were retired nurses who provided cover which ensured continuity for patients. We heard that nursing staff shortages were a concern for the ward; this was discussed at a daily 'huddle' meeting and senior staff were made aware. We were told that the ward was in the process of appointing three newly qualified nurses.

We heard that MDT meetings were held every week along with daily huddles, which were brief and focused meetings. We reviewed the MDT meeting recording template on EMIS. We liked the template, as it demonstrated input from a range of professionals. However, we found that it was inconsistently completed. We would have liked to have seen information such as the date of the meeting, names of those attending the meeting, the patient's legal status and patient/family involvement to be fully completed for every meeting held. Although we saw evidence of relatives being asked questions, we did not see them being fully involved before, during or after the MDT meeting. We heard from patients and relatives that they were not routinely invited to MDT meetings. We fed this back to managers at our end of day meeting and were advised that patients and their relatives were not routinely invited to meetings, however updates were given after the meeting. We were told that relatives and patients were always invited to any discharge planning MDT meetings held prior to discharge.

Recommendation 5:
Managers should ensure that communication between the MDT and patients/relatives is formalised and that MDT meetings are fully recorded including patient/relative involvement.

On the day of our visit, we heard that two patients had discharges that were delayed. This means that these patients have remained in hospital despite being clinically fit for discharge. We heard one patient was awaiting a welfare guardianship order to be granted whilst the other patient's placement in the community had not been agreed.

The Commission is of the view that discharge planning should begin as early as possible, preferably on admission, to prevent patients having to remain unnecessarily in hospital.

Use of mental health and incapacity legislation

On the day of our visit, three patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). When a patient is subject to compulsory measures under the Mental Health Act, we would expect to see copies of all legal paperwork in the patient's files.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments. Treatment must be authorised by an appropriate T2, T3 or T4 certificate to evidence capacity to consent. On reviewing the electronic and paper files we found one issue regarding the legal paperwork required to detain a patient. We also identified one issue on a certificate authorising treatment under the Mental Health Act (T3). We discussed these issues with the consultant psychiatrist during our visit.

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

(AWIA) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of Act. On reviewing patient files, we found all section 47 certificates to be in order.

Rights and restrictions

Due to the complex needs of the patient group on Leven ward, a locked door policy was in place. We were satisfied that this was proportionate in relation to the needs of the patient group.

When we review patient files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and they are written when a person has capacity to make decisions on the treatments they want or do not want in the future. Health boards have a responsibility to promote advance statements. We were advised that no patients on Leven ward had advance statements. We would have liked to see evidence of advance statements being promoted more in Leven ward.

We were pleased to hear that advocacy services had resumed face-to-face visits. Patients were referred to advocacy, if appropriate. We could not find evidence of advocacy involvement in the patient files that we reviewed.

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

We were pleased to hear that Leven ward had a full-time activity support worker (ASW) who worked alongside the clinical team, patients, carers and families developing and delivering person-centred activities on a daily basis. During our visit, we saw patient's engaging in activities on the ward with staff and other patients. The patients and relatives who we met with during our visit spoke positively about the range of activities on offer on Leven ward and told us that staff encouraged patients to participate in activities.

During our visit we saw an up-to-date activities timetable on the ward. In patients' files we found evidence of daily recordings of activities that had been offered to patients and whether they had participated or declined. All patients had an individualised activity care plan which was very detailed, person-centred and regularly updated. Activities on offer to patients included both one-to-one and group activities. Examples of activities that patients were involved in were: 'All Strong Gym', which was gym sessions for older adults, therapet dog, seated yoga, social groups, dancing and baking. We heard and saw that these activities were well attended.

The physical environment

There was a calm atmosphere on Leven ward on the day of our visit. The ward appeared bright and airy with pleasant art work on the walls. Feedback from relatives was that the ward was spacious and had a homely feel. The ward had a suggestion box for patients and relatives to

give feedback. Relatives did complain about the lack of wi-fi in the ward and the impact this had on patients' ability to access social media and keep in touch with friends and family.

All the bedrooms in Leven ward were single en-suite rooms. The ward had a number of quiet areas for patients and relatives to use. There was also a dedicated activity room. The ward benefitted from a pleasant outdoor courtyard areas that patients had access to during the day. We were pleased to hear that endowment monies will be used to completely refurbish one of shared gardens to create accessible and safe outdoor space. This should be completed by autumn 2023. We look forward to seeing this during our next visit

We heard that some anti-ligature work was still to be completed in Leven ward and remained a priority piece of work which sits on a risk register. We hope to see this work commenced when we next visit the ward.

Summary of recommendations

Recommendation 1:
Managers should ensure that when a welfare proxy is in place for a patient, a copy of the document stating the powers of the proxy should be held within the case notes.

Recommendation 2:
Managers should ensure that staff completing care plans undertake care plan training and refer to NHS Tayside's person-centred care planning standards.

Recommendation 3:
Managers should ensure that nursing staff include summative evaluations of care plans in patient notes that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 4:
Managers should ensure that patient/relative involvement in care planning is encouraged and recorded.

Recommendation 5:
Managers should ensure that communication between the MDT and patients/relatives is formalised and that MDT meetings are fully recorded including patient/relative involvement.

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.

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 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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