Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 14 December 2023

Where we visited

Moredun Ward is a 22-bedded, mixed-sex adult acute mental health admission and assessment ward at Murray Royal Hospital. All rooms in the ward are single and en-suite, with male and female individuals in rooms at different sides of the ward. There are enclosed gardens around the ward. On the day of our visit, there were 22 individuals on the ward, with no vacant beds. One surge bed (a temporary bed which provided additional capacity) was in use and one individual was receiving inpatient care in Ninewells Hospital.

We last visited this service in August 2022 on an announced visit and made six recommendations. We advised that managers should ensure requirements set out by medical staff were completed lawfully, and with the proper authority and safeguards in place, that locum consultant psychiatrists were able to access and undertake section 22 approved medical practitioner (AMP) training, that consideration was given to ensuring staffing numbers reflect the individual needs and challenges presented by the layout of the ward to ensure a safer environment for individuals, that Wi-Fi signal improvements were made and an additional phone line installed on the ward.

Following the visit to Moredun Ward, we received a detailed action plan and regular updates from the senior management team in relation to the ward's relocated and additional nursing stations. We heard that AMP training was ongoing, that an additional telephone line had been installed, but that the cabling work for the Wi-Fi had not yet been completed.

On the day of this visit, we wanted to meet with individuals and staff, look at the provision of care and treatment, and to follow up on the previous recommendations from our last visit.

Who we met with

We met with five individuals and reviewed their case records. We also met with five staff who described their experiences in the ward as mostly positive. We also met with one relative.

We spoke with the service manager, the senior charge nurse, the lead nurse and consultant psychiatrists.

Commission visitors

Gordon McNelis, nursing officer

Lesley Paterson, senior manager (practitioners)

Justin McNicholl, social work officer

What people told us and what we found

The individuals we spoke with on the day of our visit gave mostly positive comments. We found a theme of complimentary feedback about staff, with individuals feeling they were "patient focused" and provided "very good care and treatment" to those with complex needs. Some comments related to the ward environment and we heard the noise levels described as "the ward can be noisy" and "can be bad for my anxiety". However, it was mentioned that staff were supportive and were good at de-escalating stressful situations. Examples of staff supporting individuals during times of distress were shared, with an example being that when an individual was being restrained "they managed this with dignity and respect".

We also met with a relative who told us they found staff "approachable, respectful and made you feel supported". They felt involved with their family member's care and treatment and described them as a "very good nursing team". The relative and the individuals we spoke with thought there could be improvements with the ward landline and mobile phone reception and found it difficult to communicate with family/relatives. Improvements to the Wi-Fi signal and mobile phone reception were recommendations from our last visit. We heard from staff that modems and cabling work to improve the Wi-Fi coverage had been identified and the ligature risk associated with this assessed. This is due to be implemented in February 2024 with a view to tie in with the new HEPMA (hospital electronic prescribing and medicines administration) electronic system that will replace paper medication prescription and recording.

Some staff spoke of the challenges that staffing shortages presented. We also heard that the smoking ban in psychiatric hospitals appeared to be point of consternation, with some staff feeling unsupported by senior managers and therefore unable to challenge individuals who still wished to smoke; if they did challenge them, they were fearful of the repercussions of doing so.

Care, treatment, support and participation

Care records

Information on individuals' care and treatment was held electronically on the EMIS system. We found nursing care plans to be of a good standard, person-centred, and focused on the individual's needs. We were pleased to find evidence of nursing staff engaging with individuals and their carers/relatives, to give them an opportunity to be involved and contribute their views. We were told individual participation in developing care plans could be variable, as some individuals were unable to engage, due to difficulty in communication and understanding, however, easy read versions had been developed to make these more user friendly.

We were pleased to find care plans that focused on the physical health of individuals and the interventions to address identified concerns with signposting to appropriate professionals (GPs).

We had some difficulty finding documented one-to-one discussions between staff and individuals taking place however, our review of daily consultation notes showed that these discussions were happening, but the content of the discussions was not being consistently

recorded. We would encourage one-to-one discussion to be documented as evidence of this taking place. This was raised with managers at the feedback meeting at the end of our visit.

Recommendation 1:
Managers should ensure that the content of one-to-one discussions between individuals and staff are recorded in the care records.

We noted that do not attempt cardiopulmonary resuscitation (DNACPR) information was held in the medication kardex folder and we were told if there were any changes to this information, this would be communicated with staff at commencement of shift handover.

Multidisciplinary team (MDT)

Moredun Ward has a multidisciplinary team (MDT) consisting of locum psychiatrists, nurses, health care support workers, occupational therapy, and an activity support worker.

We were made aware of staff challenges since our last visit in 2022, with news of the whole MDT changing since then. Despite vacancies remaining, we were told the MDT were “now in a good place” and the focus had been placed on the development of working relationships within the team. Despite five rounds of band 5 (staff nurse) recruitment drives, uptake from this had not been as expected however, recruitment drives remained ongoing. We were told that to compensate for this deficit, focus had been placed on increasing the number of band 6 charge nurses (secondment), band 4 and band 3 staff.

In response to staff shortages Moredun Ward had used block booking of agency staff which recently ceased due to new staff in post, use of bank staff continues. The majority of these being Moredun Ward staff who were familiar with the environment and individuals. We were informed that a new senior charge nurse (SCN) was in post.

Recommendation 2:
Managers should ensure that the recruitment of registered nursing staff remains a key focus.

We found that the documents supporting the weekly MDT meetings gave a good description of each individual’s current situation, including any issues they wished to be discussed; we were pleased to find that discharge planning was discussed at these meetings.

It was positive to hear that individuals’ carers had access to the carers group and the ‘triangle of care’, a model that promotes liaison between the individual, their carer, and professionals, as well as the use of behavioural family therapy (BFT) in the ward. BFT is a psychoeducational model that supports family members and the individual to better understand mental health diagnosis, symptoms, and behaviours, and it promotes positive communication, problem solving skills, and goal planning.

On the day of our visit, there were three individuals whose discharge from hospital was delayed. This was due to a number of reasons including waiting for a place to become available in a residential care facility and also due to the lack of suitable accommodation in relation to individuals’ specific physical health needs. We were assured that these individuals were regularly kept under review in an effort to find suitable onward placements for them.

Use of mental health and incapacity legislation

On the day of the visit, 15 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Part 16 (sections 235 to 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. On our last visit to Moredun Ward, we made a recommendation that medication requirements set out by medical staff were to be completed lawfully, and with the proper authority and safeguards in place. The response we received in the action plan which followed this visit noted that an action was to reintroduce regular pharmacy audits and prescribing checks.

Unfortunately, from our review of the medical treatment certificates on the day of this visit, we had significant concerns that despite processes and practices being put in place, there were numerous cases where psychotropic treatment was being administered without the necessary appropriate and legal authorisation in place. We reviewed the care and treatment of all 22 individuals in the ward and found many anomalies. Some of these included cases of antipsychotic medication being prescribed, but not legally authorised by a T2 (consent for treatment) or T3 (authorisation for treatment) certificate. We found that treatment certificates were not in place when they were legally required to be, as well as incomplete treatment certificates. We found a T4 certificate that was written up in preparation for administering medication, which is not appropriate or accurate. A T4 certificate is a retrospective notification of urgent treatment to the Commission and therefore written after urgent treatment has had to be administered. It is not a certificate which authorises treatment which has been prescribed and not yet given and therefore advance planning of urgent treatment is not appropriate.

During our review we also found intramuscular (IM) 'as required' medication prescribed on a T2 certificate. 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 and any advance consent an individual had given would be invalid if they have withdrawn their consent when the medication for agitation was required, or if restraint had to be used. It is our view that IM medication prescribed 'as required' should be authorised on a T3 certificate.

There were also cases where individuals who had been admitted to the ward on an informal basis, were prescribed IM 'as required' medication for agitation. For similar reasons noted above, the Commission has concerns about IM 'as required' medication being prescribed for informal patients, as it would be unlikely that this would be administered under conditions of consent. If the patient was so distressed and exhibiting behaviour which caused concern, then their legal status would need to be reviewed and any additional 'as required' medication prescribed at that point.

In the circumstances where medication had been administered without the required legal authority, we advised the responsible medical officer (RMO) that they should write to the individuals informing them that they received treatment out with the Mental Health Act, advise them of their right to seek advocacy and/or legal advice, and of their right to make a complaint if they wish to do so. They should also inform the patient's named person if they have one.

These matters were raised with senior managers, medical and nursing staff on the day of the visit, with a discussion around the importance of medical, nursing, and pharmacy staff having responsibility and accountability in ensuring treatment is delivered in accordance with the Mental Health Act. The Commission will follow this up with the service.

Recommendation 3:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised and a system of regularly auditing compliance by all key clinical staff is put in place.

Recommendation 4:
Managers must ensure that medical and nursing staff understand their responsibility and accountability regarding the prescription and administration of psychotropic medication to all individuals in Moredun Ward.

Rights and restrictions

A locked door policy remained in place in Moredun Ward to provide a safe environment and support the personal safety of the individuals. Although we felt this was proportionate for a percentage of those who were detained, the rights of individuals who were admitted to the ward informally and who do not need the door locked must equally be fully considered, so that they can have free access to the outside world. We would expect them to receive written information and instruction, if necessary, on how to come and go from the care setting. Protocol on door locking needs to be clearly stated on admission and available to staff and visitors.

It would be good practice and beneficial for this discussion to be recorded and evidenced in each individual's care records. We were pleased to hear the locked door protocol was reviewed on a nightly basis and escalated to the medical team if changes occurred. During our time on the ward, we observed signage at the front door notifying people that the "door is temporarily locked" and were told that individuals who are informal were advised of their rights and the safety reasons for the door being locked; however, we would like to see evidence of these discussions taking place in the care records.

Recommendation 5:
Managers should ensure the NHS Tayside 'locked door in mental health settings' protocol is explained to individuals in the ward and that those who are receiving treatment on an informal basis, are informed of the procedure for accessing and leaving the ward when the door is locked. These discussions should be recorded in the care records.

The patient advocacy service had a good presence on the ward, with access to, and the promotion of the service signposted in the ward. Access was available by self-referral process or by ward staff identifying a need for advocacy and supporting the patient to arrange contact with them.

Activity and occupation

Moredun Ward had input from occupational therapists and an activity support worker who were available over seven days, including weekends.

An activity timetable was updated on a weekly basis and offered a range of structured activity, giving individuals an opportunity to engage in activities they may not have experienced before. We were told engagement from individuals could be variable, but encouragement was given to explore existing areas of interest, as well as a focus being placed on improving the physical health of individuals, with a trainer from the 'Go Outdoors, Get Active' programme attending the ward weekly. We found there was good standard of documentation in EMIS using an SBAR (situation, background, assessment, recommendation) format, that showed the rationale and benefits of activities and whether the individual participated or not. We found the activities purposeful and linked with individuals' assessment of needs.

The physical environment

On the day of our visit, the ward was at full capacity with 22 beds occupied, as well as one further individual an inpatient in Ninewells Hospital. If they returned from medical stay that would require use of one surge bed. When individuals were admitted and there was no bed immediately available for them, they could be accommodated in a 'surge bed'. Moredun Ward has access to three additional rooms for surge capacity, with senior leadership approval required to use these additional resources. We were told surge bed use in Moredun Ward tended to fluctuate, with current use down from recent daily use throughout November 2023.

From our previous visit, we identified the layout of the ward, and the impact of reduced staffing as not being conducive for individual observation. This had been partially actioned from our previous recommendation, with a protected daily floor nurse role now in place to enhance observation, increased nurse visibility, and give the individuals a sense of security. In addition to this, we were made aware of the quality improvement team working with the ward to trial the use of two separate nursing stations in the ward that were located in each of the male and female corridors. Progress of this has been delayed however, work was expected to soon commence starting in the female corridor.

Recommendation 6:
Managers should continue to ensure the ward layout is a safe environment for patients and the drive to improve observation continue.

The ward has a therapy kitchen that was often used by individuals to participate in learning activities of daily living. There was also a family room which allowed relatives to access via a separate entry without coming on to the ward.

From our previous visit, we recommended an additional phone line be installed which we were pleased to see had been completed. We were told that although phone lines were already in place, privacy and noise levels were taken into consideration when planning for this.

We were pleased to hear that NHS Tayside 'no smoking' policy was in place, as well as health promotion initiatives and nicotine replacement therapy (NRT) being offered. However, we were disappointed to hear feedback from individuals in the ward that they had observed individuals and sometimes staff smoking cigarettes in the ward grounds/garden area. We also heard some mixed views from staff regarding the 'no smoking' policy, with some believing that it was "unfair" to enforce a no smoking policy on individuals who were admitted to the ward and were experiencing stress and distress behaviours. Others told us that they felt it was

a positive initiative, however, felt that more support from senior managers on how to enforce the policy would be welcomed. These points were raised with managers at the feedback meeting at the end of the visit, and a reminder that is against the law for smoking to take place within 15 metres from a hospital building.

Recommendation 7:
Managers should ensure the NHS Tayside ‘no smoking policy’ is explained to and complied with by all individuals in the ward, and that staff are given support to manage this.

Summary of recommendations

Recommendation 1:
Managers should ensure that the content of one-to-one discussions between individuals and staff are recorded in the care records.

Recommendation 2:
Managers should ensure that the recruitment of registered nursing staff remains a key focus point to provide the ward with a balanced skill set.

Recommendation 3:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised and a system of regularly auditing compliance by all key clinical staff is put in place.

Recommendation 4:
Managers must ensure that medical and nursing staff understand their responsibility and accountability regarding the prescription and administration of psychotropic medication to all individuals in Moredun Ward.

Recommendation 5:
Managers should ensure the NHS Tayside 'locked door in mental health settings' protocol is explained to individuals in the ward and that those who are receiving treatment on an informal basis, are informed of the procedure for accessing and leaving the ward when the door is locked. These discussions should be recorded in the care records.

Recommendation 6:
Managers should continue to ensure the ward layout is a safe environment for patients and the drive to improve observation continue.

Recommendation 7:
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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 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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