Mental Welfare Commission for Scotland

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

Date of visit: 20 May 2024

Where we visited

Leven is a 14-bedded, mixed-sex, functional admission ward for older adults, typically over the age of 65. On the day of our visit, there were 14 people on the ward and no vacant beds. Leven provides care for individuals from the Tayside area.

We last visited this service in March 2023 on an announced visit and made recommendations that a document stating the powers of the welfare proxy should be held in case notes, that nursing staff complete care plan training and carry out summative evaluations of care plans, that individuals and relatives are involved in developing care plans, for communication between the multidisciplinary team (MDT) and individuals and their relatives to be formalised, and that MDT meetings fully record the individual's and relatives' involvement.

The service provided a response to these recommendations, advising the Commission that amendments were made to the admission checklist to include a request for the welfare proxy powers document, routine audits of record keeping were in place, care plan training was delivered by the mental health practice development team, regular reviews, audits of care plans and summative evaluations were recorded, a peer support model and a care plan champion role was put in place, individuals and relatives had been encouraged to be involved in care planning and whether they accepted or declined the offer to participate, this was to be recorded in the care plans.

An MDT pro forma was developed to capture updates and changes to individuals' care and treatment, which would capture individual/relative involvement and views.

Who we met with

We met with and reviewed the care of four people. Four who we met with in person and we reviewed the care notes of three. We also spoke with two relatives and met with four members of staff.

We spoke with the service manager, the clinical and professional team manager, the senior charge nurse (SCN), the consultant psychiatrist, the lead nurse, the charge nurse, other nursing staff, the occupational therapist (OT) and the activity support worker (ASW).

Commission visitors

Gordon McNelis, nursing officer

Jo Savege, social work officer

What people told us and what we found

The individuals we spoke with on the day of our visit gave positive comments about staff. We were told they were “kind”, “very nice”, that “staff saved my life”, “they look after us so well”, and “they’re good at encouraging us to be involved (in activities)”.

All the individuals we spoke with said the “food is excellent”, “there are plenty of activities to do” and “the cleaners do a great job, they are conscientious, and the place is immaculate”.

We did hear a common theme of complaint about staff availability to meet individuals’ needs when requested. We heard from a relative who felt that although the care given to their family member was “very good”, including activity staff “going above and beyond” to provide pampering/beauty treatment which “had a very positive effect (on their relative)”, they felt communication with the family could have been better. This was in relation to a lack of staff support, guidance and information during the discharge process.

Care, treatment, support and participation

Care records

Information on individuals’ care and treatment was held electronically on the EMIS system. We found admission assessments were comprehensive, gave the reader a good impression of the individual and linked with care plans, risk assessments, and risk management plans. We found these to be detailed, reviewed regularly and they corresponded with care plans.

We found one-to-one discussions between the named nurses and individuals were meaningful and detailed and were carried out regularly. An individual we spoke with mentioned “these take place anytime I want”.

We wanted to follow up on our previous recommendation regarding care planning and the involvement of individuals/relatives to develop these. Although we found nursing care plans person-centred, detailed and regularly reviewed, we did not find documented evidence of the individual or relatives’ involvement taking place in the care records. The individuals we spoke with didn’t have copies or were not aware of what their care plans contained. Where individuals were unable to fully participate in care planning due to the progression of their illness, we would have expected this to be acknowledged and documented.

Recommendation 1:

Managers should ensure that individuals and/or relatives are involved in developing care plans where possible. Their participation should be documented in care records, and they should be offered a copy of care plans. If individuals choose not to or cannot be involved, this should be recorded.

We found activity care plans to be person-centred, detailed and included information that reflected the individuals' preferences and interests.

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.

Multidisciplinary team (MDT)
A range of professionals were involved in the provision of care and treatment in the ward. This included psychiatry, psychology, the nursing team, junior doctors, OT, activity support worker, mental health officers (MHO) social work, physiotherapist and advocacy.

We wanted to follow up on our previous recommendation regarding formalised communication between the MDT and individuals, relatives/carers, and also for MDT meeting documents to be fully completed and include the views of the individuals, their relatives/carers. We were told individuals and relatives/carers were encouraged to be involved with developing care plans and their views were gathered and documented in a newly developed MDT meeting pro forma. We heard that whether they accepted or declined the offer to participate, this was also documented.

We found the views of individuals recorded in the MDT proforma which was updated at weekly MDT meetings. We saw these were completed by the individual's named nurse, associate nurses, medical staff and the wider MDT. We heard that a monthly documentation audit took place, which included reviewing the MDT meeting pro forma, with feedback given to the MDT around any documentation omissions including attendees, family/relative involvement, progress of actions etc.

We were pleased to find a good level of communication throughout the MDT proforma, which also included input from the social work discharge team. We were told that since our last visit, there was a peer support model in place. On the day of our visit, we spoke to staff who were complimentary of peer support and there was mutual respect towards each other; we felt peer support and the positive communication was evident in this cohesive team.

We were told advocacy visit all individuals in the ward, and access was available by self-referral or by ward staff identifying a need and then encouraging and supporting the individual to arrange contact with them.

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).

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act 2000 (AWI Act), including certificates around capacity to consent to

treatment were mostly all in order. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the 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. During our review of section 47 certificates, we found no evidence of the legal proxy decision maker being consulted. This was raised with ward staff during our visit, and we were told they would review section 47 certificates following our feedback meeting with a view to contacting and consulting with the power of attorney when it was reasonable and practicable to do so.

Recommendation 2:
Managers should ensure that where a welfare proxy is in place for an individual, and they have powers to decide about the individual's treatment, the proxy should be consulted and consent sought in relation to medical treatment. The section 47 certificate should evidence that this consultation has taken place.

We wanted to follow up on our previous recommendation regarding availability of a copy of the document stating the powers of the proxy in the case notes, and we were pleased to find these on file.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. On reviewing these files, we found the electronic medications Kardex's stored on hospital electronic prescribing and medicines administration (HEPMA), online system. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had not nominated a named person, we were told ward staff, MHO and advocacy encourage individuals to appoint one and promote the importance and benefits of this. However, despite this, we were told uptake by individuals varied.

Rights and restrictions

A locked door policy (currently under review) remained in place at Leven Ward to provide a safe environment and support the personal safety of the individuals. We saw a notice at the front door to the ward advising a locked door policy was in place. 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 did not need the door locked must equally be fully considered, so that they can have free access to the outside world. They should have 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 at admission and available to staff and visitors. This should include information on how the individual can come and go freely. We were told the locked door protocol was reviewed on a nightly basis and that informal patients were informed of their rights and the safety reasons for the door being locked at admission however, we would like to see evidence of these discussions taking place and recorded in individuals' case records.

Recommendation 3:
Managers should ensure the 'NHS Tayside locked door in mental health settings' protocol is explained to individuals who are admitted informally to the ward and that they are also informed of the procedure for accessing and leaving the ward when the door is locked. These discussions should be recorded in the care records.

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 is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements.

We were told staff encouraged individuals to have an advance statement by promoting them during the individual's recovery and discharge planning. Reminders were also included in the ward discharge checklist document and community mental health teams were encouraged to follow them up with individuals following discharge. However, despite these efforts, we only found one advance statement on file.

The Commission recommends that the offer of an advance statement is recorded as evidence of the person being made aware of their rights but also their right not to complete an advance statement if they choose not to do so.

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.

Activity and occupation

Leven Ward had input from their designated ASW who devised a weekly activity timetable which included input from individuals to identify and focus on their preferences and interests. The activity planner included a wide range of activity options such as knitting, yoga, social group, visits by a therapet, table tennis, hairdressing and gardening. There was also OT and an OT support worker who provided individual focused, structured and therapeutic activities that promoted and taught skills that were transferable to outside living. These included using the activities of daily living kitchen, as well as focus placed on improving the physical health of individuals with seated exercise and strengthening exercises from the 'go

outdoors get active' programme and visits to the local gym also. The staff we spoke with were complimentary and positive about the activity and occupation available on the ward. We were pleased to hear positive comments from staff, such as "I love working in Leven Ward", "there's great respect for each profession", "staff are open to change and are inclusive of others professional opinions" and "I've seen some amazing success stories (individuals progress)".

The physical environment

Leven Ward was welcoming, bright and airy with lots of tactile interactive tools placed throughout the ward and garden area that encouraged user interactivity. It was noted to be very clean and had a good presence of staff engaging with individuals. There was access to a well-maintained garden area which we were told was well used by individuals and visitors. This therapeutic and calming environment provided individuals with great views and random signage throughout prompting mild exercises.

We were told NHS Tayside anti-ligature works had not yet commenced in Leven Ward however, they were due to begin in January 2025. We were told senior management had met with NHS Tayside governance and health and safety teams to explore ways of implementing this sooner. In the interim, Leven Ward has implemented several procedures to mitigate risks such as increased use of floor nurses, continued risk assessment, including annual use of the 'Manchester clinical risk in mental health services' assessment tool and staff training on ligature and suicide awareness.

Each individual had their own ensuite bedroom which could be personalised at the individual's or relatives' request.

Summary of recommendations

Recommendation 1:
Managers should ensure that individuals and/or relatives are involved in developing care plans where possible. Their participation should be documented in care records, and they should be offered a copy of care plans. If individuals choose not to or cannot be involved, this should be recorded.

Recommendation 2:
Managers should ensure that where a welfare proxy is in place for an individual, and they have powers to decide about the individual's treatment, the proxy should be consulted and consent sought. A section 47 certificate should record this consultation.

Recommendation 3:
Managers should ensure the 'NHS Tayside locked door in mental health settings' protocol is explained to individuals who are admitted informally to the ward and that they are also informed of the procedure for accessing and leaving the ward when the door is locked. These discussions should be recorded in the care records.

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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