Mental Welfare Commission for Scotland

Report on unannounced visit to: Garry and Tummel Wards, Murray Royal Hospital, Muirhall Road, Perth PH2 7BH

Date of visit: 23 July 2019

Where we visited

Gary and Tummel Wards are both 12 bed assessment wards for the purposes of assessment and treatment for people with dementia (or awaiting a diagnosis of dementia). They provide assessment and treatment for males and females and both wards cover the Perth and Kinross area.

We last visited this service on 5 September 2018 and made recommendations in relation to care plans, completion of Section 47 certificates, provision of activities and signage.

On the day of this visit we wanted to review the progress of these recommendations, meet with patients and speak with relatives to hear their views on the care and treatment their relatives were receiving.

Who we met with

There were a total of 23 patients on the wards on the day of our visit. We met with and/or reviewed the care and treatment of nine patients over the two wards. This included consultation with relatives. We spoke to the acting senior charge nurse, acting charge nurse, clinical and professional team manager (inpatient care) and staff nurses on the day.

Commission visitors

Moira Healy, Social Work Officer and Visit Coordinator

Dr Juliet Brock, Medical Officer

Tracey Ferguson, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The family members we met on the day all spoke highly of the staff and of the care their relative was receiving. They commented that they found the staff were always available and were supportive of them particularly during difficult periods of their relative's stay. In Garry Ward in particular we heard that by agreement, relatives were contacted after every multi-disciplinary team meeting (MDT) even though the care plan may not have changed and this was highly valued. All family members spoke of feeling included in decisions regarding their relative's care and that the consultants were approachable.

Care planning

We were pleased to see an improvement in the care plans on both wards. The care plans covered both mental and physical health from the point of admission. Most were detailed, person centred and reviewed regularly however, not all were of the same standard and we suggested that the quality of care plans should be audited to ensure consistency across both wards.

Recommendation 1

Managers should audit the care plans to ensure consistent quality across both wards.

MDT meeting records were of a high standard and were detailed although some did not have an attendee list and this should be addressed. There was evidence of pharmacy being involved in both wards with a regular review of medication.

We were told that advocacy was easily accessible and responsive once referrals had been made.

Use of mental health and incapacity legislation

Paperwork relating to the Mental Health (Care and Treatment) (Scotland) Act 2003 was stored in paper files and was easy to locate. Prescribed medication was authorised appropriately on the relevant consent to treatment form (a T2) or using a certificate authorising treatment without consent on a T3. There was an audit of T2s and T3s across the wards. We found one error on a T3 form which was rectified immediately on the day.

Where a patient lacks capacity in relation to decisions about other medical treatments, a certificate completed under a section 47 of the Adults with Incapacity (Scotland) 2000 legislation must be completed by a doctor. Adults with Incapacity Section 47 certificates were in place however some treatment plans required to be more personalised and there should be evidence of a discussion with either the power of attorney of welfare guardian where appropriate. There was a recommendation in last year's report in relation to this and whilst there was some improvement with some treatment plans containing personalised information, this was not consistent throughout and this still requires attention.

On one ward certificates were stored beside the medication prescription sheets which is good practice and we were told this process would be put in place across all wards.

The Do Not Attempt Cardio Pulmonary Resuscitation forms which were held in files evidenced consultation with families where appropriate.

Recommendation 2

Managers should ensure that section 47 certificates record information about conditions for which treatment is being prescribed.

Rights and Restrictions

The door to both wards were locked on the day of the visit for reasons of patient safety. There is a policy in place and patients and their relatives are informed of the need for a locked door on admission.

On the day of the visit, there were small number of patients who required additional support with enhanced observation from nursing staff. We were told this was reviewed throughout 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

Activities

On both wards we saw nurse led activities happening on the day of the visit. We were told by the charge nurses that most activities were done on a one to one basis around individual needs and abilities although group activity was also sometimes available.

We did recognise that there has been a drive to provide improved activities on both wards within the last couple of months and this improvement was commented on by one of the relatives We were told that a case has been put forward to the executive management group for an activities coordinator to be employed across the two wards to enhance the work currently being undertaken by nurses and health care assistants.

Recording of activity was variable and this still needs attention and there was no reflective evidence on what that individual may or not have gained from this event. We look forward to seeing on future visits how the activity programmes have progressed.

Physical environment

Both ward environments were welcoming and appropriate for this group of patients. Unfortunately whilst efforts have been made in some areas, with paintings on the walls and soft furnishings in use, signage still requires attention.

Tummel ward is currently undergoing a re-fresh of décor .In Garry ward we noted damaged and scuffed walls and memory boxes outside bedrooms which were damaged or broken. One large window at the end of the corridor looked unsightly and we advised staff that this required attention. The staff team have developed a sensory relaxation room for patients and families to use on Garry ward making this environment better for patients and families.

Both wards had access to internal courtyard gardens. These were pleasant spaces with planting & visual interest. A large shared garden on the periphery offered plenty of space and seating for patients and visitors, however due to aspects of the design (uneven paved surface and sharp-edged metal planters) it was not considered a safe environment for patients to access without supervision.

Any other comments

We found staff to be knowledgeable and enthusiastic regarding all their patients. The family members we met with, spoke positively about the care on the ward but expressed concern regarding discharge planning.

A number of family members told us about their relatives having had unsuccessful discharges to care homes and this had a negative effect on the behaviour of their relative requiring readmission in a distressed state. We were told by nursing staff that some patients required readmission within short periods of time despite involvement of the care home liaison team. We will follow up on this issue further with local managers.

Recommendation 3

Managers should review cases where a patient requires readmission to the ward to ensure discharge planning arrangements and follow up support arrangements are adequate.

Summary of recommendations

Recommendation 1

Managers should audit the care plans to ensure consistent quality across both wards.

Recommendation 2

Managers should ensure that section 47 certificates record information about conditions for which treatment is being prescribed.

Recommendation 3

Managers should review cases where a patient requires readmission to the ward to ensure discharge planning arrangements and follow up support arrangements are adequate.

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 (Social Work / 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

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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