Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 9 August 2022

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.

Amulree Ward is a 20-bedded, mixed-sex rehabilitation ward at Murray Royal Hospital. On the day of our visit there were no vacant beds. The unit has a multidisciplinary team (MDT) of nursing staff, psychiatrists, psychology, pharmacy, occupational therapist (OT), physiotherapist, music therapist and an activity support worker.

We last visited this service on 31 October 2019 and made recommendations regarding care plan audits, MDT meetings, specified person process and the ward layout.

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

Who we met with

We met with and reviewed the care and treatment of seven patients. We also spoke to three relatives.

We spoke with the senior charge nurse (SCN), other members of the nursing team, the activity coordinator, the lead nurse, medical staff and other members of the clinical team. Prior to the visit, there was a virtual with the general manager and the SCN.

Commission visitors

Claire Lamza, executive director (nursing)

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with during our visit told us staff "couldn't be any better"; we heard were kind and helpful. Patients felt that staff responded well to their care and treatment needs. We heard from patients that they felt involved in care planning and decision for both mental health and physical health care needs; they advised us that they involvement included attending multidisciplinary team meetings. Patients were aware of their rights and how to exercise them. We heard that the food was good and that specific dietary needs were catered for. We also heard that there were good opportunities to participate in activities on the ward. We heard how much patients enjoyed activities such as yoga and specifically, spending time with the activity co-ordinator for the ward.

The relatives we spoke to described staff as "so good" and going above on beyond to provide care to patients on the ward. We heard from some relatives that there were staff who they felt were very engaged and supportive of the member of their family, although we did hear of concerns that patients were not always being offered the type of care that would help them cope as they moved on from the rehab service. Relatives expressed confidence in staff and found them to be accessible and approachable. Food on the ward was rated positively and the self-catering kitchen provided was felt to be a welcome addition. One person told us that their relative is sometimes bored despite the activities on offer. Relatives told us that the ward was bright and airy with a nice garden. Some relatives told us that had not seen copies of care plans.

Care plans

Nursing care plans are a tool which identify detailed plans of nursing care. Good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. On a previous visit to the ward, we made a recommendation regarding ensuring that patients participate in care planning and that care plans are audited on a regular basis.

We were pleased to hear that to support the ongoing quality of care plans and documentation, care plan audits are carried out on a regular basis by a dedicated member of staff. We also heard that to increase patient participation in care planning, the ward is developing a patient feedback form. We saw evidence of patients being offered a copy of their care plan or the reason for refusing a copy documented. We were pleased to see that some patients had completed a well-being and social functioning questionnaire as this shows further evidence of patient involvement in their own care planning.

During our visit, we saw a range of care plans that were comprehensive and person-centred and addressed both physical and mental health needs. Physical health care needs included physical health care checks, education and support, for example around healthy eating. Care plans also included goal focused activities both ward and community based.

The care plans we reviewed outlined the patient's likes and dislikes and their views in relation to treatment. On reviewing care plans, we saw evidence of patient and family involvement in decision making. We felt that we got a good sense of who the patient was.

In most of the files that we reviewed, we were clear about the goal for admission to the ward. However for one patient, we weren't clear on the goal for admission raising questions for us on how appropriately placed the patient was in a rehabilitation ward. We raised this with the senior charge nurse on the day of the visit.

Discharge planning was regularly discussed along with objectives to achieve discharge. There were clear links evidenced with the ward and community support and services.

We also reviewed risk assessments and management plans on file. These assessments highlighted physical health risks as well as identifying signs and triggers of deteriorating mental health and plans to support patients during these times. Strategies included mindfulness, self-care and time off the ward. Risk assessments on file used the RAG status (red, amber, green). Patients and their family were involved (were appropriate) in decisions around risk management.

Care plans and risk assessments mostly showed evidence of regular review. However one patient's risk assessment required to be updated. We raised this with the senior charge nurse on the day of the visit.

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 are involved in the provision of care and treatment in the ward. This includes psychiatry, nursing staff, psychology, pharmacy, OT, physiotherapy, podiatry, activity support workers, music and art therapy.

The registered mental health nursing (RMN) staff group in Amulree Ward has remained stable. RMN vacancies in the ward are relatively low; currently there are 1.6 full time equivalent. RMNs are often called up to support other sites which is challenging for staff who are aiming to maintain a rehab focus and associated activities.

During our visit, we wanted to follow up on our previous recommendation regarding ensuring that there was a record of attendance and contribution for all MDT meetings. We found that most of the meetings provided a record of attendance, although in some notes that we reviewed, this information was not detailed consistently.

We heard that Individual Clinical Reviews (ICR) are held monthly to review and discuss patient care plans and to adjust care and treatment as required. There is also a weekly MDT meeting in the ward. Again, we found that the recording of the MDT meeting was not always comprehensive however the ICR and face to face consultations with medical staff were very comprehensive and linked to the MDT decisions and discussions. There was evidence of patient participating in both MDT meetings and ICRs.

We were pleased to see that some patients were subject to the Care Programme Approach (CPA). The CPA provides a co-ordinated approach to the planning and delivery of care and

support to those with mental health difficulties. It ensures that there is a nominated care co-ordinator and that care planning is regularly reviewed. The Commission encourages the use of CPA as it is an important tool in ensuring that care and support can move seamlessly from an in-patient setting into the community.

Care records

Information on patients' care and treatment is held electronically on the EMIS system. The daily progress notes regarding patients' care and treatment mostly showed detailed information on how patients spend their day, what has been achieved and what has been challenging. In the notes we saw evidence that staff feedback the outcomes of MDT meetings to patients during one-to-one sessions. The notes also evidence one-to-one support from nursing staff and input from medical staff. However, on reviewing some patient's records, we saw periods whereby the notes were not as detailed as we would have expected. We fed this back to staff on the day of our visit.

Use of mental health and incapacity legislation

When a patient is subject to compulsory measures under the MHA, we would expect to see copies of all legal paperwork in the patient's files. Part 16 (S235-248) of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('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.

We reviewed certificates which record consent to treatment under the Mental Health Act (T2 and T3 certificates). We also reviewed mental health and incapacity paperwork. All documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act 2000 (the AWI Act), including certificates around capacity to consent to treatment and copies of welfare guardianship orders, were in place and were up to date, however, these were not easily located. At the end of day feedback, we suggested that documentation for the Mental Health Act and AWI be highlighted, and more accessible on the electronic system. The lead nurse advised us that work is underway by the NHS Tayside Central Mental Health Act office to upload all MHA documentation

We also noted that when reviewing the T3 certificates, there were several of these that where the medication that had been prescribed, this now required review, specifically in relation to the type of intramuscular (IM) medication that had been noted. We would suggest that medical staff undertake an audit of the T2 and T3 certificates on the patients' records.

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 (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. We were able to locate all section 47 certificates, where appropriate, on patients' files. However we did not always find accompanying treatment plans. We raised this with staff on the day of our visit.

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 a patient had nominated a named person, we found details of this in the patient's record.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions to be regularly reviewed. It also provides the appropriate framework for the review of the restrictions and informs the patient of their right to appeal against these. During our visit, we wanted to follow up on our previous recommendation regarding reviewing current processes in relation to specified persons and ensuring all necessary documentation is completed and regularly reviewed. We were told that specified person status is discussed and reviewed in a weekly MDT meeting. Where a patient had been made a specified person, we found a clear rationale for this, the measures that were in place, a record of review of the measure and notification to the patient about this decision and their right of appeal.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

Rights and restrictions

Amulree Ward operates an open door policy however the door is locked overnight to ensure safety and security. This is reviewed on a nightly basis.

On the day of our visit, we were aware that Amulree ward has required to use continuous intervention (CI), as set out in the guidance provided by Health Improvement Scotland for Improving Observation Practice.
https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention/

We were concerned to hear that where this was in place, the level of restriction for individuals meant that engaging in a rehab programme was not possible, and that the rehab environment was adversely affected when CI was in place for an extended period of time. We discussed this situation with senior staff on the day, and were concerned to hear that transfers out of the rehab unit, to an appropriate care setting where CI could be undertaken without creating unhelpful restrictions on patient care, was difficult. We would suggest that managers review the internal transfer process and where patients require care in a more intensive and safer environment, that they receive this in a timely way.

We were pleased to see that for patients whose first language is not English, there was a translator on the ward on a daily basis. Additionally Speech and Language Team (SALT) provide communication aids such as Talking Mats.

When we are reviewing patient files we look for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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 in the future. Health boards have a responsibility for promoting advance statements. While we were pleased to see that more than half the patients on Amulree Ward had an advance statement, on the day, we discussed with staff that rehabilitation services were ideally placed to support patients in developing these. We noted

that where patients did not have an advance statement, we mostly saw evidence of attempts to engage patients in discussions regarding the reason for refusal. However we saw one advance statement that required review, and raised this with staff on the day of our visit; we were advised that the patient had refused to participate in a review, and asked that this be noted in the patient's file.

We made suggestions of how advanced statements could be promoted in the ward and directed staff to our advance statement good practice guidance that is available on our website: https://www.mwcscot.org.uk/node/241

Recommendation 1:
Managers should ensure the promotion of advanced statements, to provide an opportunity for patients to make decisions and choices about their care and treatment.

We were pleased to hear that nursing staff regularly encourage and promote the use of advocacy services. Unfortunately the local advocacy service do not have much of a presence on the ward. We understand that there is a plan in place to have the local welfare rights organisation provide regular input on wards across the Murray Royal site.

Activity and occupation

We heard that there is a full-time activities worker based on Amulree Ward. Along with third sector organisations, a number of activities are offered including: paddle boarding, 'Love Active' gym and yoga sessions, mindfulness, trips to the community along with educational activities provided on the ward. There is a patient suggestion box regarding activities and feedback is positive. Patients have an activities timetable which is kept in their room. During our visit we observed patients participating in activities with the activities co-ordinator and OTs.

The physical environment

The layout of the ward allows patients to have access to various areas and rooms where they can engage in activities, or relax in different settings without the environment feeling noisy or busy. The ward has quite a modern feel to it, with distinct areas that staff try and maintain separately for male and female patients, while encouraging participation and engagement for all.

There is a good balance of smaller, quieter areas where patients are able to sit and listen to music, or participate in one-to-one activities with a degree of privacy, to larger, busier spaces where patients can freely join/meet with one another, such as the TV lounge, and the pool/snooker and table tennis areas.

As noted in our previous report, there continues to be efforts to balance a homely feel with the rehabilitation function of the unit. There are educational posters about health eating and smoking cessation, information leaflets for patients and carers, a recovery tree painted on the wall next to the main meeting rooms, with message of hope and achievements, and an accessible read version of the activity programme all being visible around the ward. There is a large whiteboard in the main corridor setting out the daily activities that are scheduled and one that notes which staff will be on duty for the day.

Patient rooms were en-suite, spacious, and modern and there was an opportunity to personalise these with their own items. There is a locked drawer for patients to keep their personal items securely.

There are a several well-established outdoor areas that Amulree has access to. There is a large fenced off garden directly off the main TV lounge, where there has been some progress in setting up a specific area that will be used for growing plans and vegetable. We heard on the day that this work is ongoing. There is also a small courtyard garden which was well maintained and used regularly by patients and visitors when they are on the ward. There is also a large open space that staff and patients use for exercise and social activities.

During our visit, we wanted to follow up on our previous recommendation regarding the need for rooms to be adapted for present more opportunities for patients to trial more independent living and extending the current kitchen to include opportunities for all patients. However, we were advised that the inclusion of kettles and toasters had been deemed as a risk and they were subsequently removed. Kettles and toasters have now been placed in communal dining rooms. While there have been efforts made to create additional rehabilitation-focused areas, such as the smaller dining space, the large kitchen area remains lacking in promoting atmosphere, or opportunities to engage in self-catering. We also heard that patients have been unable to attend to their own laundry due to all of the washing machines in the ward breaking down repeatedly.

Recommendation 2:
Managers should address the environmental issues, such as the communal dining area and laundry facilities, so that patients can fully engage in the rehabilitation process.

Any other comments

We heard from staff how challenging the last 18 months has been as a result of the pandemic. We were told of the challenges of being unable to spend time in the community with patients and having to instead develop more ward based activities. This had a significant impact on patients. Along with this, discharges from hospital were delayed resulting in considerable anxiety for patients. Despite these challenges, we were impressed to hear how staff had pulled together to continue to provide a quality service.

We heard that 25% of patients on Amulree Ward are delayed discharge. This means that they remain in hospital despite being clinically fit for discharge. These delays are due to housing and support requirements. The Commission is of the view that discharge planning should begin as early as possible on admission to prevent patients having to remain unnecessarily in hospital. We would like to see managers working closely with their colleagues in social work to ensure a discharge planning process is developed and implemented.

Summary of recommendations

Recommendation 1:
Managers should ensure the promotion of advanced statements, to provide an opportunity for patients to make decisions and choices about their care and treatment.

Recommendation 2:
Managers should address the environmental issues, such as the communal dining area and laundry facilities, so that patients can fully engage in the rehabilitation process.

Good practice

We were pleased to hear of the positive impact that the activity support worker has made to the engagement of patients in meaningful activities. This is alongside the art and music therapist. Good relationships have also been built with community teams which should result in a seamless service from an in-patient to a community setting.

We were also pleased to hear that the team are committed to working towards Royal College of Psychiatrists Quality Standards accreditation and we look forward to hearing more about this.

Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving 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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