Mental Welfare Commission for Scotland

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

Date of visit: 23 January 2024

Where we visited

Amulree Ward is a 20-bedded, mixed-sex admission and assessment ward based at Murray Royal Hospital. Amulree Ward primarily provides rehabilitation for individuals resident in Tayside.

On the day of our visit, there were 18 people on the ward and two on overnight pass.

We last visited this service in August 2022 on an announced visit and made two recommendations that related to promotion of advance statements and environmental improvements to enhance patient participation in the rehabilitation process.

Who we met with

We met with, and reviewed the care of six people, six who we met with in person and five who we reviewed the care notes of. We also met with one relative.

We spoke with the senior nurse and the lead nurse.

Commission visitors

Gordon McNelis, nursing officer

Tracey Ferguson, social work officer

Denise McLellan, nursing officer

What people told us and what we found

The individuals we spoke with on the day of our visit gave mixed views of the ward with some telling us they "felt safe" and it was a "nice environment", while others mentioned the environment could be "chaotic" and "some (staff) listen to you more than others".

Other comments mentioned were "staff are approachable", they were "genuinely nice people" and individuals felt "treated with respect". What was raised with us were some concerns about the choice of food, and some felt there was not enough fresh food on offer.

Although some individuals were unhappy about being in the ward, they did mention that they were aware of their rights. We also met with relatives who gave praise for staff and described them as "absolutely incredible" and "they couldn't get any better". We also heard from relatives that they felt there could have been better contact with families at the admission stage but following this, they felt more involved and reassured thereafter.

Care, treatment, support and participation

Care records

Information on individuals' care and treatment was held electronically on the EMIS system. We found care records to be in good order. The care plans were of a good standard, person-centred, focused on the individual's mental and physical health needs, and were regularly reviewed. We were made aware of speech and language therapy (SLT) input to help individuals' understanding of the content of care plans.

We were pleased to hear that to support the ongoing quality of care plans and documentation, care plan audits were carried out on a regular basis by a dedicated member of staff. We found evidence of nursing staff engaging with, and regularly encouraging individuals and their carers/family to participate and contribute their views to the development of care plans and were offered a copy of these when complete. Some individuals chose not to engage in this process, and this was documented in the individual's notes. The records showed one-to-one support from nursing staff, although we found these did not take place as often as we would have expected.

On the day of our visit, there were three delayed discharges, and we were informed this would soon be reducing to two. Discharge was delayed for these individuals due to challenges finding appropriate speciality onward placements. We were told the discharge co-ordinator continued to follow progress and update the ward accordingly.

There was attention to physical health care needs, which included regular physical health monitoring and ongoing support. We heard that no general practitioners (GPs) were attached to the ward, however there were plans for this to be explored alongside a physical health clinic that focused on individuals who are subject to high dose antipsychotic monitoring, clozapine monitoring, blood tests/venepuncture and electrocardiogram (ECG) procedures. We were pleased to hear of a newly appointed health psychologist in place to help support and prioritise physical health concerns, although this role covers all of Tayside, including acute wards.

Multidisciplinary team (MDT)

A range of professionals were involved in the delivery of care and treatment in the ward. This included psychiatry, nursing staff, health care support workers, psychology, occupational therapists (OT) and activity support workers. Recruitment drives were ongoing for registered mental health nursing (RMN) staff group.

Full MDT meetings were held weekly and were well attended by all MDT members. We found the documents supporting these to be robust and in good order. They provided a detailed record of discussions and focused on all aspects of individuals' care and treatment, including future planning and goal setting. We found evidence of individuals being invited to and participating in MDT meetings.

Use of mental health and incapacity legislation

On the day of the visit, 17 people were subject to a compulsory treatment order (CTO) and detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act). The individuals we spoke with said they had an understanding of their rights and what it meant to be detained under the Mental Health Act.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and mostly corresponded to the medication being prescribed. During our review, we found one error on a T3 certificate, which was discussed with the team. They advised that this would be rectified.

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. We were told that six people had nominated a named person and saw evidence of this in the records we reviewed.

Rights and restrictions

There was generally an open-door policy in Amulree Ward with the door only being locked from 8pm for safety and security purposes. This was reviewed on a nightly basis, and there was a locked door policy in place for times when the door was locked.

Individuals could access advocacy services by self-referral, or ward staff could refer them. Ward staff promoted and encouraged advocacy support during regular patient meetings. We were told all individuals who were newly admitted to the ward were given information packs that specified advocacy information for each locality, should they wish to self-refer.

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 an individual is a specified person in relation to this, and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we had difficulty finding appropriate documentation for some individuals and noted a lack of reasoned opinions, which should detail the rationale as to why an individual is subject to specified person restrictions. We would expect to find a recorded reasoned opinion

that supported the restrictions imposed on an individual held in the care records, and notification of specified persons to be sent to the Commission.

Our specified persons good practice guidance is available on our website.

Recommendation 1:
Managers should review current processes in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

Recommendation 2:
Managers should consider MDT training in the application and use of specified persons to ensure all staff are cognisant with all aspects of this legislation.

When we are reviewing 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. During our visit, we wanted to follow up on our previous recommendation regarding improved promotion of these. We were told seven individuals had advance statements and despite improvements with promotion and prompting, many individuals had declined to complete these when offered. Nursing staff evidenced these prompts by recording conversations in the individual's notes. We were also told that mental health officers (MHOs) encouraged individuals to complete advance statements and we were pleased to find that the record of the MDT meeting indicated that advance statements discussions were taking place at each meeting.

Activity and occupation

Amulree Ward had input from a dedicated activity support worker and OT who provided informative displays around the ward of the activities that were on offer. We heard that activities were available and took place on a one-to-one or group basis. We found a varied range of activities on offer that not only focused on preparing individuals for discharge and maximising their independence, but others that placed emphasis on improving their physical health.

Individuals in Amulree Ward praised the activities, and those delivering them, and they told us they enjoyed the keep fit and yoga sessions. Additional activities came from the 'Get Outdoors, Get Active' programme that raised awareness strengthened the links between physical activity and health.

Activity participation was recorded on EMIS. The recordings were of a high standard and detailed the rationale and benefits of each activity and noted whether the individual participated in these or not.

We were pleased to hear that the joint improvements made by Amulree Ward staff and the quality improvement team, had been recognised with an award for 'innovations in improving physical health and wellbeing' at the Mental Health Nursing Forum (Scotland) awards 2023.

The physical environment

The entry to Amulree Ward was welcoming, with the ward being well maintained, bright and airy. We found the atmosphere and environment to be calm and relaxed. All the bedrooms in Amulree Ward were single en-suite and had been personalised.

There was a variety of areas for individuals and relatives to use. There was a notice board highlighting the wards achievements, and information on their progression towards adopting the 'safewards' model of care. This model encourages staff and patients to work together to make the ward safer and reduce conflict and subsequent containment events. The notice board detailed psychology groups, as well as peer support worker contact details and health promotion posters. The ward has two dining rooms, a quiet room, and had access to two separate internal garden areas, in addition to a larger garden area for individuals to use. These garden areas were all well-maintained.

During our visit, we wanted to follow up on our previous recommendation regarding ward improvements that would enhance the individual's participation in the rehabilitation process. We were told the dining area had been redecorated and access to the OT kitchen was promoted as part of a home-style model of care and recovery process. We heard that the washing machine was repaired and available for individuals to use.

Yearly ligature assessments were due to take place, and NHS Tayside's operational anti-ligature work continues across the general adult psychiatry wards. This included the planned installation of anti-ligature observational doors that would ensure safe monitoring of individuals whilst providing privacy and maintaining dignity. We look forward to seeing how this work has progressed at our next visit.

Summary of recommendations

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Managers should review current processes in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

Recommendation 2:
Managers should consider MDT training in the application and use of specified persons to ensure all staff are cognisant with all aspects of this legislation.

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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