Mental Welfare Commission for Scotland

Report on unannounced visit to:

Morar Ward, New Craigs Hospital, Leachkin Road, Inverness, IV3 8NP

Date of visit: 25 October 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.

We were keen to visit Morar Ward as our last visit was in March 2021, and this was done virtually due to Covid-19 restrictions, therefore we were unable to see the environment of care or review patient records. When we last visited, we made recommendations about the provision of adult acute care beds, discharge planning for patients with complex care needs, and the choice of therapeutic and recreational activities that were available for patients.

Morar Ward is an adult mental health assessment and treatment ward for up to 24 patients. Two beds are designated for patients with problems relating to substance use. However, due to clinical need, these are regularly occupied by patients with acute mental health needs. The ward was busy on the day of our visit and frequently there are patients boarded out to accommodate new admissions.

For this visit, we wanted to follow up on the arrangements made since the Covid-19 pandemic with regard to staffing, activity provision and the environment. We also wanted to speak to patients and to staff to see how the situation had changed since restrictions have eased. We were particularly interested to hear about the impact on patient care and the effect of any additional pressures on relatives, family, staff and the overall health and wellbeing of patients.

We heard from nursing staff that that there were challenges around staffing the ward. In particular, there were absences noted due to sickness levels. This has resulted in bank staff being utilised to fill the gaps in nursing staff for the ward. Despite this, both staff and patients reported that staff employed were consistent and this provided a positive impact on the quality of care.

Who we met with

We met with and reviewed the care and treatment of seven patients.

We spoke with the service manager, the charge nurse and other clinical staff.

Commission visitors

Douglas Seath, nursing officer

Mary Leroy, nursing officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

Care, treatment, support and participation

All of the patients we met with during our visit spoke highly of the staff in the ward and they spoke positively of the care, treatment and support they had been receiving. We heard that staff treated patients with dignity and respect, were approachable and made time when patients needed to speak to someone. However, patients told us that they were aware of the nursing staff shortages and felt their care would benefit from having more staff available to them. During our visit, we witnessed staff spending time with patients by engaging in one-to-one activities.

We were pleased to find that care plans were clear, detailed and showed evidence of review. They were goal and recovery focused with clear interventions and plans for discharge. A person-centred model of care planning was clearly evident. We found evidence of patient participation in care plans. However, when a patient chooses not to be involved or was unable to be involved in care planning, we would expect to see the reasons for this recorded in the patient's plan.

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

In the files we reviewed, we saw comprehensive risk assessments which were person-centred and showed evidence of review. The files included evidence of multidisciplinary (MDT) meetings and of one-to-one input from nursing staff. The MDT also gave patients the option to attend or to have their views represented and this was clearly documented. There was also good use of the care programme approach (CPA) for complex cases, both for patients who were under compulsory measures or those whose admission was voluntary.

To support ongoing quality of care plans and documentation, there were regular audits undertaken by the nursing team to assist with improvements in quality and governance.

Those individuals that we spoke with told us that during their stay on the ward "some staff are amazing with lovely smiles on their faces but some come across as really stressed". However, we did hear that for some, they "don't always feel safe on the ward – it can be very noisy". We heard about "the ward meeting that I go to once a week and go in with the nurses and junior doctors. It can feel a bit forbidding with all the people, but they do discuss meds and try to tell me what they are doing"

We heard that there is input into the ward from a range of different disciplines. There are two dedicated consultant psychiatrists (only one is permanent) for the ward and input from pharmacy, physiotherapy, occupational therapy. The main deficit on the ward is the lack of input from clinical psychology. We were told by the clinical team that having psychology involved in the ward would be beneficial. The team recognise that providing a model of care that offers psychological therapies along with psychological formulations would enhance care and treatment for all patient groups. Previously, there had been input with sessions on

cognitive behavioural therapy (CBT) twice weekly. This has been discontinued in the absence of psychology input.

Recommendation 1:
Managers should ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and patient groups.

The main pressure on the ward, though, remains the reduction of bed numbers and time spent by nursing staff trying to accommodate new admissions, with patients regularly boarded out or spending time at home on pass.

Recommendation 2:
Managers should review the provision of adult acute care beds at the earliest opportunity.

Use of mental health and incapacity legislation

On the day of our visit, many of the patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The appropriate detention paperwork was readily available.

Part 16 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. We found that none of the T2 or T3 consent to treatment certificates were available together with prescription sheets. They were located elsewhere in files and so were not on hand for nurses to check which treatments had been authorised or consented to. We found issues with some prescriptions where intramuscular, as required treatments should not have been authorised for informal patients. We checked and confirmed that none of the treatments had been administered. We raised this on the day of the visit with the senior charge nurse and agreed that the necessary alterations needed to be made.

Recommendation 3:
Administration of 'if required' IM psychotropic medication almost always requires the legislative authority of the Mental Health Act. Managers should ensure that all prescribed treatments are legally authorised and are reviewed at the weekly MDT meetings.

When we were reviewing patient files we were looking 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 a decision on the treatments they want or do not want. Health boards have a responsibility to promote advance statements. We found some evidence of advance statements being recorded by patients in the ward. The Commission supports advance statements, as they are a way of ensuring that people with mental ill health are listened to and have their human rights respected. We would like to see evidence of the attempts made to engage in a discussion regarding advanced statements and the reason noted for any patient that does not have one.

Our advance statement good practice guidance is available on our website https://www.mwcscot.org.uk/node/241

Rights and restrictions

The ward had a locked door on the day of the visit; this is commensurate with the level of risk identified with the current patient group. Information on the locked door policy was available at the main entrance to the unit. There were individual risk assessments in place for patients, which detailed arrangements for time off the ward and the support required to facilitate this safely.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are subject to detention 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 is regularly reviewed. On the day of our visit, there were no patients who were subject to these procedures.

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

During our visit we spoke with a number of patients who were subject to Mental Health Act legislation and others who were in hospital informally. Of those patients we spoke to, not all were aware of their rights and restrictions placed upon them. One patient said "I think I am on a CTO". Another said "I was a voluntary patient and as far as I know I still am, they have never told me". This uncertainty may lead to individuals not knowing their rights or being able to exercise them.

However, we were informed by both patients and staff that advocacy is available in the ward and the uptake is good.

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

Activity and occupation

We heard from patients and staff that due to limited staffing and sickness, the availability of daily recreational activities on the ward can be compromised. This results in the essential delivery of patient care and treatment being prioritised by nursing staff over the provision of therapeutic activities. The delivery of activities for patients in wards is generally supported by the appointment of therapeutic activity nurses.

Patients we spoke to felt that more use could be made of the social centre, and we heard that "it is not open that much" and that "there used to be a shop and there were always people there – now you can go only at specific times and there might be four or six people".

One patient recalled that "there used to be the pottery, art, pony trekking, and other activities – and you could do things like gardening - it was good – you could gain confidence by doing things". We heard from patients that "it all seems to be academic like doing decider skills

courses - they can be good but it depends on your frame of mind – it can be really boring that stuff if you are already feeling negative".

We were pleased to hear that there are still woodland walks on Thursdays. Patients felt that there should be a shop on site; the nearest shop is a 20-minute walk away.

Recommendation 4:
Managers should consider the employment of activity co-ordinators in order that there is a dedicated resource that is not affected by the level of clinical activity.

The physical environment

The ward benefits from a number of communal areas including a spacious sitting room, a dining room, a large therapy dining kitchen, several smaller sitting areas and a private garden space. The ward environment was clean, tidy and free from any unpleasant odours. However, the décor was in need of a refurbishment.

Due to the level of activity, many patients felt that there is a lot of noise and nowhere to go for peace and quiet. They also complained that the windows can't be opened so there is no air flow and it can be extremely hot in warm weather.

On a previous visit to the ward, we were made aware of a white board in the main office that contained confidential patient information. Attempts have been made to keep the information on this board discreet. A film has also been placed over the window to the office so that it cannot be viewed from outside the office looking in. However, it was clear on the day of our visit that that the board can be viewed by patients and external visitors from the day room and by those entering the office. Confidential patient information continues to be displayed on the white board and can be clearly viewed. Whilst we recognise the benefit to staff from having this information easily accessible, we are concerned about the visibility of confidential information. We would like to see alternatives solutions being considered.

Recommendation 5:
Managers should ensure that white boards do not contain confidential information identifiable to patients. Alternative solutions should be sought to ensure confidentiality is maintained.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is dedicated clinical psychology input into the ward to support the development of psychological therapies and interventions across the staff and patient groups.

Recommendation 2:
Managers should review the provision of adult acute care beds at the earliest opportunity.

Recommendation 3:
Administration of 'if required' IM psychotropic medication almost always requires the legislative authority of the Mental Health Act. Managers should ensure that all prescribed treatments are legally authorised and are reviewed at the weekly MDT meetings.

Recommendation 4:
Managers should consider the employment of activity co-ordinators in order that there is a dedicated resource that is not affected by the level of clinical activity.

Recommendation 5:
Managers should ensure that white boards do not contain confidential information identifiable to patients. Alternative solutions should be sought to ensure confidentiality is maintained.

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.

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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