**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:**

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

**Date of visit:** 14 March 2023

## 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.

Affric ward is a 10-bedded intensive psychiatric care unit (IPCU) situated in the main building in New Craigs Hospital. An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require a more intensive level of observation. IPCUs generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often distressed patients.

We last visited this service on 25 January 2022 and made the following recommendations; managers should audit care plans to ensure that they link with risk assessments and include person centred detail with regular reviews; and managers should identify a system of auditing consent to treatment forms to ensure that treatment given is legally authorised.

The response we received from the service was that procedures had been introduced to bring about improvements in these areas.

On the day of this visit we wanted to follow up on the previous recommendations.

## Who we met with

We met with and reviewed the care and treatment of six patients. As this was an unannounced visit, we were unable to meet with any carers or relatives on the day of our visit.

We spoke with the hospital manager, the charge nurse, clinical psychologist, activities co-ordinator, clinical director and service manager.

## Commission visitors

Douglas Seath, nursing officer

Justin McNicholl, social work officer

# What people told us and what we found

## Care, treatment, support and participation

Most 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 were visible around the ward, were approachable and listened to patients. Staff were described as welcoming and those that we spoke with told us that they had good connections with staff. During our visit we saw staff communicating and interacting with patients on the ward.

There was evidence of input from psychology, with psychological formulations being undertaken, and outcomes shared with the multidisciplinary team (MDT), to assist with their understanding of a patient's presentation and behaviours. Physical health screening was evident, assessments were ongoing, and care plans related to physical health needs were in evidence.

When we last visited the service, we found care plans were not sufficiently detailed and lacked a clear link to risk assessments. For this visit, we found that all patients in Affric Ward had a completed 'Getting to Know Me' document included in their clinical notes by day seven, following admission. We were pleased to hear from the leadership team that regular audits of care records, including care plans, are part of a governance programme in Affric Ward. This ensured that documentation held in a patient's care record was of a good standard and allowed the ward-based leadership team to support nursing staff in their endeavours to work with patients collaboratively.

While care plans were in place for each patient, we would like to have seen more detail of how goals and interventions were agreed with patients. We would also like to have seen more evidence of how those goals were considered and how patients were involved in the process. We recognise that, at times in an IPCU, patients will be too unwell to engage in a discussion regarding their care plan, however we would like to see evidence of the attempts that have been made recorded in patient records. Whist there was evidence of reviews being undertaken, these were not consistent in nature or frequency.

The unit had an MDT of nursing staff, psychiatry, psychology, pharmacy, and occupational therapy staff. However, we did note that those who attended those meetings were primarily the consultant psychiatrist and the nursing staff. We found detailed minutes completed after the weekly meeting but these did not always record attendance and did not effectively link with specific areas described in care plans nor were care plans routinely re-evaluated and updated afterwards.

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

**Recommendation** 1:
Managers should ensure that care plans are person-centred, demonstrate patient involvement and have clear evidence of goal setting, interventions and review.

## Use of mental health and incapacity legislation

The ward accepts patients who are admitted either directly to the unit, from other wards or from the courts. At the time of our visit all patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 (the CPSA).

Paperwork relating to the Mental Health Act was filed appropriately and was easy to access in the files. We reviewed forms for consent to treatment under part 16 of the Mental Health Act (T2 and T3 forms). However, the forms were not always present with the prescription sheets. Best practice is for consent to treatment forms to be kept together with prescription sheets so that nursing staff are aware whether the medication being dispensed has been legally authorised. In two cases, there was an issue about the T3 forms and the 'as required' medication authorised in the forms; we discussed these and addressed this issue on the visit.

**Recommendation 2:**
Managers should identify a system of auditing consent to treatment forms in order to ensure any errors are immediately rectified so that treatment given is legally authorised.

## Rights and restrictions

For reasons of patient safety and other risk factors, the IPCU is a locked ward and patients are not freely able to leave the ward. The function of an IPCU ward is to provide care and treatment to patients who require intensive support, who may be acutely unwell and who may display significantly stressed or distressed behaviour. For an IPCU to function appropriately there needs to be the opportunity for patients to be able to move back to acute/specialist wards when either clinically ready to do so or when beds become available.

IPCUs are small, highly staffed units that provide short periods of rapid assessment, intensive treatment and stabilisation for patients. Where this rapid turnover does not happen we follow up on individual patients' circumstances to ensure unnecessary restrictions are not being enforced. We discussed with managers cases where there were patients whose stay had been prolonged and will follow these up after the visit.

Other restrictions can be put in place only with due legal authority. Two patients had been made specified persons and were subject to restrictions placed upon them under sections 281-286 of the Mental Health Act. The Commission would expect restrictions to be legally authorised and the need for specific restrictions regularly reviewed. The forms were in place with the required timescales observed and reasoned opinions included as required by the legislation.

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

On the day of our visit there were patients who required additional support with enhanced levels of intervention from nursing staff. We were told that patients who were subject to continuous intervention are reviewed daily. The clinical team discussed the patients care and treatment to determine whether the patient's level of intervention can be safely reduced. Patients were encouraged to participate in this process. There was recognition from the

senior leadership team that continuous intervention was at times necessary, in order to support patients during the acute phases of distress and illness, although it can be considered a restrictive practice. In the IPCU, there are a number of restrictive practices commensurate with the level of risk. There are requirements to ensure that safety to patients and staff is not compromised and that procedures are in place to reduce potential risk to safety and security. All patients in the ward had access to advocacy. The patients we spoke to were aware of their rights to legal representation. Nursing staff provided contact details of lawyers and opportunities for patients to meet with their legal representatives.

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 comments from several patients who at times felt there were not sufficient activities to do in the ward, and that they felt bored. We heard that the social centre has been closed throughout the Covid-19 epidemic. There was one member of staff previously engaged in working as an activities lead at the social centre who provided ward-based activities. However, they were the only resource across a number of wards. On the day of the visit, we heard about plans to develop the post of a ward-based activities co-ordinator. The post will be used as a resource for activities, alongside the physiotherapist on and off ward, which we agreed would be helpful for patients. We also noted there was to be a review of funding for occupational therapy. We think it is important that there is account taken of the importance of activities in a ward of this kind and that managers continue to review activity provision. We look forward to seeing how this has progressed when we next visit.

Patients and staff told us that activities mainly occur on a one-to-one basis due to the acute level of illness. Nursing staff try to provide a range of activities but this is dependent on the level of clinical activity and other demands on their time.

**Recommendation 3:**
Managers should review the level of activities available so that there is consistency of provision with patients having individually assessed programmes in place.

## The physical environment

When we visited, we found that the unit was clean and bright. There were 10 single en-suite rooms, a communal sitting area, and an activity/ games room with pool table. The hospital gym is currently not in use.

There was an enclosed garden space. We found that patients were regularly able to get fresh air, and this is particularly important for patients who were currently unable to leave the ward. However, the area could benefit from some upgrading and we would encourage managers to consider this.

## Summary of recommendations

**Recommendation** 1:
Managers should ensure that care plans are person-centred, demonstrate patient involvement and have clear evidence of goal setting, interventions and review.

**Recommendation 2:**
Managers should identify a system of auditing consent to treatment forms in order to ensure any errors are immediately rectified so that treatment given is legally authorised.

**Recommendation 3:**
Managers should review the level of activities available so that there is consistency of provision with patients having individually assessed programmes in place.

## 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.

## Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk