Mental Welfare Commission for Scotland

Report on unannounced visit to:

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

Date of visit: 16 May 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 able to be carried out face-to-face.

Bruar Ward is an eight-bedded, mixed sex, locked rehabilitation unit for patients, some of whom may have come to psychiatric services through contact via a forensic route. We last visited this service on 16 May 2022 and made recommendations that files were kept in good order so that they provided an accurate record of care and treatment; that MDT training in the application and use of specified persons should be considered and that an audit system to monitor the use of restrictions should be introduced.

The response we received from the service in relation to the previous recommendations was that procedures have been introduced to bring about improvements in the areas highlighted in the previous report. On the day of this visit, we wanted to review the progress of the previous recommendations and also look into some concerns raised with the Mental Welfare Commission.

Who we met with

We met with and or reviewed the care and treatment of four patients. We also received comments from relatives either by telephone, e-mail or on the day of our visit.

We spoke with the associate director of nursing, the senior charge nurse, 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

Patients we interviewed were mainly complimentary about the staff in Bruar Ward. One patient said “they are absolutely amazing”. For other patients, the experience was not always so positive and we were unable to have detailed conversations in all cases due to the level of their disability. However, we were able to observe patients throughout the day, interacting with staff in a positive manner. One relative said that staff were “polite, respectful and caring”. However, some concerns were raised by relatives about difficulties in the continuity of care; with many bank and agency staff employed, many have become “regulars” over time. Where appropriate, families are invited to attend meetings. However, some concerns were raised about access to review meetings for those unable to attend in person. It was good to see that patients were given the choice to attend, or to have their views represented if unable to do so. We were assured that efforts were being made to ensure that patients and relatives who could not attend in person should be able to do so remotely in future.

When we last visited the service we found examples of detailed and person-centred care plans compiled by the multi-disciplinary team (MDT). These addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. As well as doctors and nurses, the multi-disciplinary team included occupational therapists, psychologist, physiotherapist and social workers. A pharmacist also attended ward rounds. There was a clear focus on rehabilitation; all individuals in Bruar Ward were encouraged and supported to build skills in establishing a structured routine. This appeared to be an approach that all individuals participated in. However, engagement varied depending on the individual’s motivation and mental state. We thought more could have been done to evidence patient involvement in the record. Nursing records were completed to a high standard, care plans were very detailed, and we noted clear documentation of adverse incidents. Reviews of care plans were largely carried out in a timely way, though not in all cases. Risk assessment and management plans were reviewed as part of the weekly MDT ward round, but such reviews were not always reflected or updated in the original risk assessment and management document.

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 demonstrate patient involvement and, together with risk assessments, should have clear evidence of regular review.

Use of mental health and incapacity legislation

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (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. Certificates authorising treatment (T3 and T2) under the Mental Health Act were present and held in patient files, where required.

We found the monitoring of legislative matters in both Mental Health and Adult with Incapacity Act (Scotland) Act 2000 (AWI Act) to be fully compliant with requirements.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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. Section 47 certificates were present in files, where appropriate, with attached treatment plans. Where patients were subject to welfare guardianship under the AWI Act there was a copy of the powers in the file.

Rights and restrictions

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 is regularly reviewed. We looked at records involving individuals who had been made specified persons. The forms were in place, with the required timescales observed and reasoned opinions were provided, as required by the legislation.

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 were reviewed daily. The clinical team discussed the patient's care and treatment to determine whether the level of intervention could be safely reduced. Patients were encouraged to participate in this process.

All patients in the ward have access to advocacy and some have used the service and found it helpful.

When we reviewed patient records we looked 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. Health boards have a responsibility for promoting advance statements. An advance statement under ss274 and 276 of the Mental Health Act is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. We found some evidence of advance statements made by patients in the ward. Patients were encouraged to complete one, but did not always wish to do so.

The Mental Welfare Commission has produced advance statement guidance which can be found at: advance_statement_guidance.pdf (mwcscot.org.uk)

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

Activities in rehabilitation wards are essential to ensure recovery planning that aids with patients re-integration into the community. We were pleased to hear from patients and noted from our observations that occupational therapy (OT) and physical health technician provision for the ward was valued. Generally, patients that we spoke to seemed content with the activities that were available to them. Activities were based on personal choice and were recovery-focused. There was range of activities on offer, and these included cooking, budgeting, shopping, self-care, use of public transport and use of community services. Some patients mentioned there were difficulties in getting access to the hospital gym. There was concern at the loss of the social centre, though we were reassured that a new approach was to be piloted in one of the other wards which may restore some of the type of activities offered previously by the social centre.

Patients moving towards discharge were actively involved in preparation and cooking of their own meals, in order to develop the skills they will require when living more independently. All individuals had their own room with personal belongings, as well as having a range of activities around the hospital and in the community. There was good evidence of individuals building skills, e.g. being able to access meaningful activity, such as working as volunteers, engaging in further education or simply in learning to access public transport for pre-discharge visits home.

The physical environment

There were eight single en-suite rooms that were personalised, and in keeping with individual's interests. The ward was bright and airy with communal spaces that could be busy, but also quieter rooms and activity rooms that were well resourced and well used. There was a pleasant room for interviews, a main day area and separate dining space. The ward had direct access to a garden and other outdoor space. The bedrooms appeared homely and well presented. However, the main area of ward itself appeared fairly stark and clinical, with all walls painted magnolia. Patients did mention how hot the ward could become in warmer weather with the inability to open windows, though we are aware that this is a hospital wide issue. The ward also lacked a sluice room, though we were assured that this had been discussed with experts in infection control who have given advice on how this can be safely managed.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plans demonstrate patient involvement and, together with risk assessments, should have clear evidence of regular review.

Service response to recommendations

The Commission requires a response to this recommendation 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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