Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 25 July 2023

Where we visited

Ruthven Ward is a 24-bedded mixed-sex dementia assessment and complex care ward, with 23 patients admitted on the day of our visit. The ward is split in two with 12 patients in each side. Patients who are admitted to Ruthven Ward are acutely unwell, and often experiencing acute stress and distress associated with a deterioration in their cognitive abilities, or are in crisis as a result of their cognitive impairment. Admission to Ruthven Ward is required when care and treatment options are beyond the intensive support available in the community, where the person has either not responded to treatment or has raised levels of risk as a result of their presentation.

We last visited this service on 13 July 2022 and made recommendations relating to multidisciplinary team (MDT) notes containing information on decisions taken and actions required; that there should be an audit of care plans; that copies of proxy powers should be located in relevant patient files; that managers should carry out an audit of all do not attempt cardio pulmonary resuscitation (DNAPCR) forms and; that managers should ensure programmes of activity were in place.

The response we received from the service was that a system of audit and review 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/or reviewed the care and treatment of seven patients. We also met with two relatives.

We spoke with the deputy charge nurse, lead occupational therapist, and interim service manager.

Commission visitors

Douglas Seath, nursing officer

Margo Fyfe, senior manager

What people told us and what we found

Care, treatment, support, and participation

Most of the patients we met during our visit were not able to engage in a discussion about their care and treatment due to the extent of their cognitive impairment. However, we did spend time on the ward speaking to some patients, where appropriate, and observing them. Throughout the visit we saw kind and caring interactions between staff and patients, and staff we spoke with knew the patient group well. Visitors we met with praised the staff highly, saying their relatives were very well looked after, and commented that they felt listened to, and that staff have time to talk and provided updates and information in a timely fashion.

We found care plans in place for stress and distress around personal care. There were records where the Newcastle model had been used to formulate the approaches taken to manage stress and distressed behaviours; these were seen to be in use on the day of our visit. Clear formulations were in place and easily accessible in the patient's file. However, many of the care plans lacked sufficient personalisation and reviews did not specifically relate to goals and objectives set out in the care plans. Care plans were located in the daily care notes and were generally updated six monthly but not consistently.

There was a new care planning system being piloted where we saw a range of needs including physical health care, with goals and interventions that were required to meet these needs. However, some of the care plans lacked detail in terms of what specific interventions were required to achieve the desired outcome. It did appear to be targeted at the physical health needs for those in a general adult care setting, rather than for the patients whose mental health needs were a priority.

Risk assessments were in need of review, many not having been updated for some considerable length of time. Physical health screening was evident, assessments were ongoing, and care plans related to physical health needs were in evidence.

DNAPCR forms were available in the files, with evidence of discussion with nearest relative or welfare proxy.

Copies of welfare guardianship and Power of Attorney powers were also located in files and where required, covert medication pathway paperwork ensured that this procedure was authorised in all cases. Getting to know me documentation was partially completed where assistance and input from relatives was given.

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 review of risk assessments is given urgent attention.

Recommendation 2:
Managers should ensure that nursing staff include summative evaluations of care plans in patient notes that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 3:
Managers should ensure that patient/relative involvement in care planning is encouraged and recorded.

Multidisciplinary team (MDT)

The ward routinely had input from five consultant psychiatrists who cover the whole of the north Highland catchment area, with one consultant taking the lead for inpatients. There was periodic input from occupational therapy (OT), psychology, physiotherapy, and pharmacy, but they generally did not attend MDT meetings.

However, we were advised that there were only two occupational therapists to provide cover for all psychiatry wards in the hospital, in supporting the wards with assessments and some activities. As a result, this service was stretched, and activity programmes were very limited. Input from other professionals including psychology, dietetics, speech and language therapy, and other specialist inputs was arranged on a referral basis.

We found that MDT notes were more like ward round updates, with only medical and nursing staff in attendance, although they did contain a forward plan for the week ahead. We did not find much evidence of the carer's views recorded either in the notes, at meetings, or on an ongoing basis.

Recommendation 4:
MDT meetings should be recorded as distinct from weekly ward reviews with efforts made to engage the wider team and with carers input recorded as appropriate.

Use of mental health and incapacity legislation

Patients detained in the ward under the Mental Health (Care & Treatment) (Scotland) Act 2003 (the Mental Health Act) had the necessary documentation filed appropriately and this was easy to access.

Part 16 of 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. Treatment must be authorised by an appropriate T2, T3, or T4 certificate to evidence capacity to consent. On reviewing the electronic and paper files we found no issues regarding the legal paperwork required for those patients who were detained under the Mental Health Act.

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 (AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence

that treatment complies with the principles of Act. On reviewing patients' files, we found that s47 forms were present and accompanied by treatment plans.

Rights and restrictions

Due to the complex needs of the patient group in Ruthven Ward, a locked door policy was in place. We were satisfied that this was proportionate in relation to the needs of the patient group.

We were pleased to hear that advocacy services had resumed face-to-face visits. Patients were referred to advocacy where appropriate. We could not find evidence of advocacy involvement in the patient files that we reviewed.

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

Due to the nature of many of the patients' illness, their involvement in activities were limited. We found evidence of activities being offered to patients on the day, whether they had participated or declined. These activities included both one-to-one and group work involving the occupational therapist, three activity assistants, and staff who were previously available from the social centre which no longer functions as a separate unit. Activities that patients were involved in included music, walks, quizzes, and exercise. However, we did not find evidence of these activities being planned or recorded, so it was difficult to know how often these took place and who participated.

We were surprised to hear that occupational therapy staffing had been drastically cut back prior to the Covid-19 pandemic with six posts being lost. There was a plan to train staff in carrying out assessments of activity needs, with the three rehabilitation assistants being augmented by staff from the social centre to give a greater range of choice for patients.

Recommendation 5:
Managers should ensure that there are programmes of activity in place for each individual and clarify the roles and responsibilities of those involved.

The physical environment

With the ward divided into two 12-bedded areas, this seemed more manageable for the nursing team to meet the care needs of the group of patients. We heard that the gender mix could be problematic, but the generous nurse-to-patient ratio allowed for better observation of patient interactions.

Ruthven Ward offered a pleasant environment; patients were accommodated in single rooms with en-suite facilities and there was easy access to communal areas that were well maintained. Patients had access to an enclosed garden area and the courtyard offered a pleasant outside space.

The layout is conducive to having the ward managed as two smaller units, as is the current practice, however the ward was not originally designed as a dementia assessment facility and there are now refurbishment plans that have been developed to create a more dementia-friendly focus. Funding has been identified to support this and the senior charge nurse is involved in the planning and design. We look forward to seeing the result in future visits. While this takes place, the patients would be moved to another empty ward to minimise disruption during this time.

Summary of recommendations

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Recommendation 4:
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Recommendation 5:
Managers should ensure that there are programmes of activity in place for each individual and clarify the roles and responsibilities of those involved.

Service response to recommendations

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