Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 4 Dr Gray's Hospital, Pluscarden Road, Elgin IV30 1SN

Date of visit: 17 and 18 October 2023

Where we visited

As part of a series of visits to more rural adult acute inpatient admission wards, the Commission undertook an unannounced visit, commencing in early evening, and continuing into the morning of the following day, to better understand what activities were available, and how care and treatment was provided in settings that did not have the same access to facilities available in more urban inpatient units.

Ward 4 in Dr Gray's Hospital is an 18-bedded adult acute psychiatric admission. The ward also provides admission to older adults, young people and individuals with a learning disability and/or autism who have a mental health diagnosis. On the day of our visit there were 17 patients in the ward. We last visited this service in May 2022 and made recommendations with regards to specified person legislation and location of treatment certificates; on this visit we wanted to find out how the service was implementing the recommendations, as well as meet with people and review care and treatment.

Who we met with

When we plan a visit, prior notice is given to individuals and relatives of our intention to visit. Given that this visit was unannounced, we were unsure if we would have the opportunity to speak with individuals and relatives, however we managed to speak with 11 individuals and we reviewed the care and treatment of seven.

We spoke with senior charge nurse (SCN), charge nurse (CN), other nursing staff, recovery nurse and consultant psychiatrist.

Commission visitors

Tracey Ferguson, social work officer

Lesley Paterson, senior manager (practitioners)

Dr Juliet Brock, medical officer

Graham Morgan, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

Each individual that we met with was at a different stage of their recovery. Whilst some were preparing for discharge, others had recently been admitted to the ward and there were a few who had been in hospital for a longer period of time. The levels of acuity varied in the ward, as well as the complexity of some individuals' care needs, which then had an impact on patient experience. Most individuals told us that they felt safe in the ward, a place where they got better, although one told us that they felt unsafe and a few people told us that they were unhappy being in the ward. We heard from some individuals that the ward could be quite hectic and stressful, however we were also told that "the nurses deal with it in a very kind manner". Almost all individuals told us that the staff were kind and caring and one person told us "they will do anything you need at any time, nothing is too much bother". One individual described the SCN as the "best", whilst another individual told us that they felt re-assured as "someone comes round the ward every fifteen minutes to check we are ok". Quite a few individuals told us that being in the ward had helped them.

Most people who were detained under the Mental Health Act were aware of their rights and told us about their involvement with advocacy, however, there was one individual who told us that they were unsure what they would do if they were unhappy. Individuals told us about their involvement in their care and treatment, having the opportunity to discuss this regularly with the doctor. One told us that their doctor always explained their treatment to them and asked for their opinion around whether the medication was working or not. Others described the doctors as "understanding and kind", whilst another told us that their physical health was well looked after.

Some were able to tell us about their discharge planning and of the follow up support in the community that they would receive. We spoke with a few individuals who told us that they felt stuck in the ward and that there were no plans in place to help them move on from hospital. We heard about the benefit in having one-to-one sessions with ward staff and the recovery nurse as part of their recovery journey, although others told us that they were never offered one-to-one sessions. Most individuals told us that there was not much to do on the ward and often felt quite bored.

We asked about visiting times to see if there were any restrictions in place. The SCN told us that visitors of all ages could visit the ward at any time but did prefer protected times around meals and this is what individuals told us.

In terms of staffing, the SCN told us that since our last visit, and mainly due to high staff absence, the ward has had to frequently use agency staff in order to provide sufficient cover in the ward.

The SCN told us that individuals who are admitted to Ward 4 may be known to the community teams, such as the community mental health team and learning disability team. We were also told that there was a liaison team who was available 24 hours, seven days a week, which included an advanced nurse practitioner and this service could assess and admit individuals to the ward. We were told that where an individual had a diagnosis of dementia, they would

likely be transferred to Muirton Ward, which is a specialist ward for people with dementia at Seafield Hospital and where an individual had a learning disability, there would be consultation with the NHS Grampian clinical lead for learning disability services to consider if a move to the specialist learning disability wards at Royal Cornhill Hospital was required. The SCN told us that the ward had good links with community teams and contact was maintained throughout the individual's admission, where they were known to a team.

Nursing care plans

From the files we reviewed, we found nursing assessments that were completed on admission, along with a risk assessment and risk management plan, however many of these documents were incomplete and completed to a variable standard. Many files had documents that were not signed or dated, and many provided little detail. Some admission assessment documents had recorded 'see previous notes' in various sections and therefore could not be viewed as stand-alone documents.

We saw some evidence of one-to-one sessions between individuals and staff that were detailed, and provided a helpful progress update about the care and treatment of the individual, along with incorporating their views and wishes into the sessions; this however varied greatly across the files we reviewed.

The level of detail in the care plans was also variable. While some were reasonably detailed and person-centred, others lacked detail, many were not signed or dated by nursing staff, and the individual's participation was unclear. We found some care plans where there were no regular meaningful reviews recorded in the file and no evaluations that helped to determine if the current care plan was working. We did find some care plans that were developed following a change to the individual's circumstances, however, the comparison in the standard of documentation from this visit to our last visit was concerning. We found one care plan where it was recorded that the individual's 'learning disability' was viewed as a barrier. We viewed this as unacceptable, as there was no context provided.

On our last visit we noted that staff were linking the daily recordings to care plans, which were clear and meaningful, however this was not evident on this visit. We asked the SCN about the audit process in place and were told that there had been mini audits done however, the SCN had already noticed that the standards were not being adhered too. We were told that due to other pressures in the ward, the SCN and CN had not been able to complete regular monthly audits to identify areas of improvement.

The SCN told us how they would often have to be counted in the shift numbers due to staff shortages, and it was the same with the feedback from the recovery nurse.

From our previous visit we were aware that the ward was developing a patient booklet in conjunction with Moray well-being hub, however, we were informed that this had not progressed due to other pressures in the service. We will continue to link in with the service and Moray well-being hub about this.

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 there is a regular audit process in place to improve the completion of all documentation and to ensure that one-to-one sessions are taking place regularly and clearly identified in the notes.

Recommendation 2:
Managers should ensure that there is a regular audit process in place in order to improve the quality of care plans to ensure that they reflect and detail interventions which support patients' towards their care goals, along with regular reviews, summative evaluations, and evidence of individual and carer involvement/participation.

Multidisciplinary team (MDT)

We were told that MDT meetings continued to be held every week with all six consultant psychiatrists who admit patients to the ward. The MDT meeting consisted mainly of the consultant psychiatrist and nursing staff. Individuals were well supported to attend and participate in the meeting or had opportunity to meet with their psychiatrist before or after the meeting, if they preferred.

We were told that the MDT document was completed at each meeting, and we saw this document in the files we reviewed. The document recorded who attended, along with actions and outcomes, however the level of detail varied across the files and some differed between the nursing and medical files. We found where there had been incidents regarding changes to the level of individual risk, changes in legal status or agreed changes in time out of the ward; this was not always documented on this form. Managers told us that there continued to be active social work and mental health officer involvement in the MDT process at various stages of the individual admission process.

We were aware of a patient's discharge, where the delay had been significant and we will continue to follow this up with the health and social care partnership (HSCP) and responsible medical officer (RMO).

We heard that the ward continued to have access to allied health professionals (AHP's) and psychological services via a referral system. However, we found there were several individuals in the ward who we felt would have benefitted from psychology input due to their complex presentations. We found that nursing staff were managing a diverse group of individuals, and were required to have a varied range of skills and knowledge, however there did not appear to be a robust MDT approach in some individual's recovery that would support them in moving forward as part of their care and treatment. We were told that there could be difficulties in progressing some individual discharges due to their complexity, and we were also advised that managing certain presentations on the ward, in the current environment, was also challenging.

We were made aware that individuals would be referred to occupational therapy (OT) prior to discharge if required.

Nursing staff told us that they received fortnightly clinical supervision by the psychotherapist, which they found beneficial. We were also told that due to pressures in the service there have been times where the sessions had to be cancelled.

Recommendation 3:
Managers should ensure that all sections of the MDT meeting record are completed, specifically information on time out of the ward, specified person status and risk management and completion should be audited.,

Recommendation 4:
Managers must ensure that there is dedicated psychology provision made available to the individuals in the ward.

Care records

Case files were in paper format, and each individual had a separate nursing and medical file, which were organised into separated sections. The recovery nurse recorded their contact with individuals in a further separate file. In these files, we found some recordings for individuals who were no longer in the ward, which was of concern. We continued to hear about the plans for NHS Grampian to move to a new electronic system soon. We were told that there were ongoing pilot sites testing the system, across the health board and we heard how nursing staff now recorded the daily handover shift on TRAK care. Moving to an electronic system will be an opportunity for records to become integrated which will be positive, as there were some aspects of current record management that were disjointed. We suggested to managers that they needed to ensure that the new electronic system will fully meet their needs and lend itself to robust and detailed recording for all MDT professionals.

Use of mental health and incapacity legislation

On the day of the visit, 10 individuals were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) and we found that the detention paperwork for the files we reviewed were in order.

Part 16 (section 235-248) of the Mental Health Act sets out the conditions under which treatment may be given to individuals who are detained, and 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, apart from two, where we found that those certificates were located in the nursing files. This was disappointing as we had made a recommendation following last year's visit that all treatment forms should be stored together with the drug prescription sheet. Following a recent audit by pharmacy across NHS Grampian we were aware that a laminated good practice guidance is being inserted into all drug prescription sheets which was good practice, and this is what we found on this visit. There was an issue with one T3 certificate, where we found that a medication was being prescribed that was not authorised; we brought this to the manager's attention to address.

On our visit last year, we were pleased to see that no informal patients were prescribed or administered 'as required' intramuscular (IM) medication. Administration of 'as required' IM psychotropic medication almost always requires the legislative authority of the Mental Health

Act. The Commission is concerned when IM 'as required' medication is being prescribed for informal patients, who are not detained under the Mental Health Act. This is because it is unlikely that those individuals would consent to receive this treatment if it had to be administered in circumstances where restraint was required. On this visit we were concerned to see that IM medication had been prescribed for two patients who were not detained under the Mental Health Act. We had been told that the service had access to the liaison service that was available 24 hours therefore, we consider it best practice for an urgent medical review to be arranged if there are exceptional circumstances where IM medication may be required, to ensure individual rights are protected. The Commission followed up on this matter after our previous visits to another service area, and have continued to follow this matter up with senior managers of the health board and the health and social care partnership (HSCP). We are aware that the NHS Grampian rapid tranquilisation policy was being updated and therefore we will write to NHS Grampian senior managers and the chief officers of the HSCP to request an update.

When reviewing files, we looked 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. We were told that one of the patients had an advance statement in place, however we could not find a copy in the current nursing file. We brought this to the manager's attention and requested this to be followed up, as from the information we had received, there were concerns that the advance statement had been overridden, although due process was not followed.

There was a staff clinical area that had a white board with individuals details recorded and we were told that this was to provide a quick overview for staff. However, from speaking with staff and reviewing files we found that the information on the board was not recorded accurately, leading to confusion and a lack of clarity between the staff. There was no recording on the board about individuals who were subject to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act). We found that there were two individuals who were subject to welfare guardianship orders however, there was no copy of the order in individual's files and this specific legal order was not identified in some of the records. We found some section 47 adults with incapacity certificates in files that were completed in accordance with the AWI Act code of practice for medical practitioners, however we found the lack of recording and awareness concerning, as it was not clearly recorded which legal frameworks were in place.

We also found a few entries that appeared confusing as to which section of the AWI Act that the patient was subject to. We found a few entries which simply recorded "AWI in place". We brought this to the attention of the SCN on the day, as we considered that this lack of detail and clarity led to confusion amongst clinical staff.

Following the Commission's recent *Authority to discharge* project, the Scottish Government provided funding to develop an AWI Act framework for staff and this has continued to be progressed jointly by the Commission and NHS Education for Scotland (NES). We will continue to keep the HSCPs and NHS Grampian updated of this development, as it can enhance staff knowledge when working and supporting people subject to AWI Act legislation.

Our *Authority to discharge* report can be found via the link below:

AuthorityToDischarge-Report_May2021.pdf

Recommendation 5:
Managers should ensure that copies all section s47 certificates, be stored with the drug prescription sheet.

Recommendation 6:
Managers must ensure that where an individual is subject to AWI Act legislation, such as power of attorney or welfare guardianship, that a copy of the order is kept in the nursing file and that nursing staff clearly document in the nursing file and patient board as to what the specific order is in place.

Recommendation 7:
Managers should provide a new patient information board and ensure that all pertinent information, including demographic details and legal status is accurately recorded and maintained on the board.

Rights and restrictions

The door to the ward was open on the days of the visit and the SCN told us that although the ward had an open door policy, at times due to the risk or safety of a patient, a decision was made to lock the door for short spells of time and that individuals were informed of this.

From viewing the patient information board and in speaking with staff, we were initially told that there were two individuals who were on continuous interventions, however we were later advised that they had just been reviewed at the MDT and this was no longer in place. We were told that due to the current environment, specific individuals' presentation could have an impact on others. We were aware from reading one file that the strategies to manage the individual's stress/distress was for them to be encouraged to spend time in their room. We were aware that NHS Grampian does not have a seclusion policy in place, as had been identified during another visit. We therefore advised the SCN and senior managers to link in with the NHS Grampian group who were devising the policy.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on individuals who are detained in hospital. We found one individual who had been made a specified person with regards to this legislation however, all the required documentation was not in place. The Commission made a recommendation with regards to specified person legislation following last year's visit, so we raised this with the SCN and senior managers on the day of the visit. We were told that the service would meet this recommendation through regular audits and this would also be reviewed as part of the MDT meeting. However, we were disappointed to find the specified person section of the MDT meeting record for the individual was incomplete. We were given an assurance that this would be remedied for this individual.

For those detained under the Mental Health Act, we were able to find documentation in the files that authorised time out of the ward (TOW), however we also found TOW documentation

for informal patients, where it recorded the time out allowed in each day/week, which was of concern, as informal patients should not be restricted in this way.

We found that the documentation for approving the time out was not regularly updated and the reviews were inconsistent. From reviewing records, we found that there had been discussions at the MDT, but that the specific TOW documentation was not updated following the MDT meeting. This was concerning as we consider this lack of clarity confusing and may lead to individuals having more restriction in place than is necessary.

Individuals who are not detained under the Mental Health Act should not have restrictions in place without the correct legal authority. We understand that some patients may prefer to go out with staff, or choose not to go out and had discussed this with the clinical team, which was confirmed by what we heard from some individuals. However, we heard from others who told us that they were 'not allowed' out and we could not find any recorded views where they were had agreed to the TOW plans which were in place.

Recommendation 8:
Managers must ensure that the time out of the ward document is updated following each MDT meeting and records individual views.

Recommendation 9:
Managers must ensure that informal patients time out of the ward is discussed at least weekly at the MDT meeting and that individual views and consent is sought with regards to the agreed time out of the ward.

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

Activity and occupation

The ward had a games room that individuals used to play pool, table tennis, and there was some gym equipment. Some individuals told us that they enjoyed playing pool and we saw this on the day of our visit. However, most individuals told us that there were not enough activities to do, which often led to boredom.

We were aware from our last visit that a recovery nurse was being appointed and we had a discussion on the day regarding the benefits that this role had brought to an individual's recovery following admission to the ward. We spoke to individuals who told us about these sessions, although we heard that those sessions were only available Tuesday to Friday and sometimes sessions were cancelled. One patient told us that it was "fantastic" being able to meet with the recovery nurse and how meditation had really helped them, but also told us that there were no activities or therapeutic interventions in place over the weekend.

We spoke with the recovery nurse who told us that they received supervision from the psychotherapist which was beneficial and that they had completed specific training around psychological therapies, such as cognitive behaviour therapy, and dialectical behavioural therapy. Appointments were offered to individuals to identify therapeutic interventions that would support their recovery and then the recovery nurse would arrange further meetings. The recovery nurse told us that the role had not been formalised, therefore due to staffing

pressures she could be often pulled into the numbers in the ward. Unfortunately, we saw this on the day of our visit.

Senior managers told us that they are in the process of recruiting for an activity coordinator to work between Ward 4 and Muirton Ward. This will be a welcome addition to the MDT as we did hear that more activities would be appreciated. We look forward to hearing how this progresses. Where patients were receiving support from the Scottish Association for Mental Health (SAMH), we were able to see this recording in the patient files.

Recommendation 10:
Managers should ensure an activity programme spanning seven days of the week is offered and also give consideration to protected, supernumerary time for the recovery nurse role.

The physical environment

The ward compromised of dormitories and single ensuite rooms. The ward had a kitchen where individuals could access the facilities, such as make tea/coffee or use the washing machine if they wished.

The ward did not have any dedicated garden space as it was on the first floor. Windows on the ward were sealed and did not open, providing no opportunity for fresh air into the ward. Some bedroom and bathroom doors continued to have no locks, resulting in a lack of privacy and dignity for patients and we continued to hear about this from individuals. We were concerned to hear about another incident on the ward where windows in a room had been smashed and shards of glass fell to the ground below the building. Concerns again had been raised, which we also share, about the potentially serious consequences of this had there been anyone passing by.

Individuals and staff continued to tell us about the lack of privacy due to individual bedroom and bathroom doors not locking. We remained concerned that no changes had been made to the environment since our previous two visits and that this ward continues to not meet the needs of individuals in relation to privacy, dignity and wellbeing whilst they are on the ward.

However, since our last visit, the Commission had continued to receive updates from Moray HSCP chief officer and were pleased to hear that they have identified a suitable option in order to carry out the required works in Ward 4. We will continue to liaise with the chief officer to receive updates.

Any other comments

It was evident from this visit that the staffing shortages were impacting on the SCN's ability to carry out the leadership role that is required for the ward. The staffing team appeared dedicated and committed to their role however, the current accommodation continues to clearly impact on the delivery of safe care. The HSCP appear to have identified a solution for the required upgrading work although this may also have a negative impact on staff and individuals. We therefore feel that the role of the SCN will be especially crucial at this time. Senior managers need to ensure that the SCN is provided with the time to commit to their leadership role in order to lead the service through this unsettling period and continue to support the necessary, required improvements.

Summary of recommendations

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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.

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