Mental Welfare Commission for Scotland

Report on announced visit to: Morar Ward, New Craigs Hospital, Leachkin Road, Inverness, IV3 8NP

Date of visit: 14 November 2023

Where we visited

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.

We last visited this service in October 2022 and made recommendations about clinical psychology input, the provision of adult acute care beds, the legal authorisation of prescribed treatments, activity co-ordinators, and patient identifiable confidential information.

We were keen to visit Morar Ward to review the service response to the recommendations that had been made during the previous visit.

Who we met with

We met with and reviewed the care and treatment of nine patients and one relative. We spoke with the service manager, the charge nurse, the hospital manager, the clinical director, and other staff.

Commission visitors

Douglas Seath, nursing officer

Mary Hattie, nursing officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

We were told the ward is nearly always at, or over capacity, and for patients and staff this can be a challenge. We heard that frequently there are patients boarded out in other wards to accommodate new admissions. Recently, where admissions have occurred out-of-hours, and no beds were available, a bed was placed in a small sitting room to accommodate the patient.

We were keen to speak with patients and staff about the environment in Morar Ward, as we were told during our last visit that there were issues with the heating, which were an issue for patients and a daily challenge for ward-based staff.

We heard from nursing staff that there were challenges around staffing the ward. During the visit, we heard that there were absences noted due to sickness and maternity leave. This resulted in bank and agency staff being utilised to fill the gaps in nursing staff team for the ward. Despite this, both staff and patients reported that staff employed were consistent, and this created less of an adverse impact on the quality of care.

During our visit, we witnessed staff spending time with patients by engaging in activities. However, patients told us that they were aware of the nursing staff shortages and felt their care would benefit from having more registered nurses available to them on an individual basis. We saw that four nurses on the day were involved in enhanced engagement and interventions, with individual patients where risks had been identified.

There were two dedicated consultant psychiatrists (only one is permanent) for the ward and input from pharmacy, physiotherapy, and occupational therapy. The main deficit on the ward, as we reported last time, is the lack of input from clinical psychology. We were informed that there are psychologists employed in the Health and Social Care Partnership (HSCP), but their time is almost exclusively devoted to making initial assessments. A further post has been advertised.

The main pressure on the ward, though, remains the reduction of bed numbers that increased during the pandemic, which have not yet been reduced. This has led to an increase in time spent by nursing staff trying to accommodate new admissions, with patients regularly boarded out or spending time at home, on pass.

Care, treatment, support and participation

Individuals we met with on the day of the visit provided feedback that was varied in terms of their experiences in Morar Ward.

From some individuals, the feedback was largely positive. One patient was very satisfied by their experience in the ward. They said that staff listen to them and were supportive and available to talk should they need this. However, others felt the “ward is always very busy, with little time to speak with staff”. One person commented on the general level of acuity of illness of others and reported not feeling safe at times.

Risk assessments need to be carried out to ensure that risk is appropriately managed throughout an individual’s admission. Where risks had been identified, those were communicated, and safety plans were put in place. In patients’ files, we saw robust risk assessments that were comprehensive and up-to-date. Reviews of risk were carried out at

each multidisciplinary team (MDT) meeting and the record provided a good understanding of risks and care needs for the person.

Care plans in general, however, were fairly basic, often with minimal information about mental health, but with a strong focus on activities of daily living needs. While we were able to identify several care plans that would be considered person-centred, this was not consistent across all care plans that we reviewed. There were several care plans that were very detailed and individualised. However, there were care plans that would have benefitted from greater participation from individuals who were receiving care and treatment. For some patients there was no clear discharge plan, with some having been in an acute admission ward for more than one year.

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 the audit of nursing care plans and reviews fully reflect the patients' risks, needs and goals in mental health aspects of care and involve patients in the process.

Multidisciplinary team (MDT)

Morar Ward has a range of professionals providing input into the ward. With consultant psychiatrists and mental health nursing staff typically providing care and treatment, the ward also benefits from input with occupational therapy providing support throughout the week.

The MDT meet weekly to review and discuss individuals' care, treatment and progress; we found these meetings to be well-documented. Individuals and their relatives are invited to, and supported to, attend meetings. There was a recognition that not all individuals wished to attend review meetings. Therefore, their views were sought prior to the weekly meeting.

The MDT notes were informative and of good quality, and we were pleased to see that they also included a forward plan.

We were told that community mental health teams (CMHT) took an active role in keeping in contact with individuals who were known to their nurses. This helped to communicate the patient's progress, from admission to discharge back to the care of the CMHT.

However, there were concerns about the absence of community mental health services should a patient experience a crisis. Currently, Highland HSCP does not have a crisis mental health service for individuals who may require support at home out-of-hours, seven days of the week. We were told patients who experience a mental health crisis at home were more likely to be admitted to hospital.

This absence of a crisis service may be a factor in the pressure on beds in the hospital, as there may be no alternative support available to patients in this situation. There was also an impact on patients who would be considered for early discharge from hospital, as currently

they are not able to return home with support that would be provided should there be an intensive home treatment model in place.

Recommendation 2:
Managers should ensure that there is dedicated clinical psychology input to the ward to support the development of psychological therapies and interventions across the staff and patient groups.

Recommendation 3:
Managers should review the provision of adult acute care beds at the earliest opportunity and seek to provide crisis and home treatment alternatives to hospital admission.

Use of mental health and incapacity legislation

The majority of patients in the ward were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act), and the documentation for this was available in files we reviewed.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained people, 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 where required, and corresponded to the medication being prescribed. We found that all T3s had been completed by the responsible medical officer (RMO) to record non-consent; they were available and up-to-date. There were a small number of anomalies in T2 and T3 forms but these were highlighted to managers and quickly dealt with on the day of the visit.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the individual's file.

Rights and restrictions

Morar Ward continues to operate a locked door to the ward, commensurate with the level of risk identified with the patient group. There was a locked door policy in place and information was available to all visitors who entered the ward.

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 this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where a person was specified, and restrictions were in place under the Mental Health Act, we found reasoned opinions in place.

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

When we reviewed individual's 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 pleased to see some individuals had made their views known by completing an advance statement and copies of those were held in their care records.

We were also informed by 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 were told by several individuals that they had regular input and support provided by occupational therapy (OT). With a recent appointment of an activity co-ordinator, this has complemented the ward's OT provision. Additional support, assessment and treatment continues to be provided by OT staff. The OT had a valuable role in providing individuals with formal functional assessments, along with recreational and therapeutic engagement.

With the engagement of an activity co-ordinator, evidence of when activities had taken place, who had participated and whether those activities had befitted an individual's daily routine was now regularly recorded. We recognise an activity, whether in a 'formal' sense or recreationally, has the opportunity for engagement between individuals and the ward-based team.

This post has only recently commenced, however, and comments from patients such as "we don't get outside enough" and "it is very boring here" reflect this.

Another comment "I was escorted to a huge hall once which was meant to be a gym but it had no equipment. If there used to be a properly equipped gym here, why isn't there anymore?" indicated a similar frustration.

Patients we spoke to felt that more use could be made of the social centre which is open only for one hour each day.

The physical environment

We visited the garden to find out whether it functioned as a therapeutic and recreational space. We were disappointed to find it appeared to be only used for individuals to smoke cigarettes or 'vape'. As the door to the garden was accessed through the sitting / dining room we were aware of the strong smell of cigarette smoke and vaping odour in the sitting room where individuals ate their meals, engaged in therapy and attempted to relax. We were told by individuals we met with this caused significant stress, particularly for those who are non-smokers or are attempting to stop smoking.

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 from the sitting room 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 still be viewed by patients and external

visitors from the door to the office. Confidential patient information continues to be displayed on the white board and can be clearly viewed.

As indicated earlier, due to the high clinical activity, some patients did not feel safe in the ward, more so amongst female patients. This is an issue in other adult acute wards where measures have been taken to provide a female only sitting room or area in mixed sex wards.

We heard during the visit that, due to an issue with ligature risk reduction and temperature regulation, the ward is to undergo an upgrade to deal with the issues identified. This would be a good opportunity for managers to consider whether a dedicated female only area can be considered and identified at this time.

Recommendation 4:
Managers should ensure that white boards which contain confidential information identifiable to patients cannot be observed from any part of the ward.

Recommendation 5:
Managers should ensure that the ward is a pleasant environment for all patients and ensure smoke is not permitted to enter via the external doors.

Summary of recommendations

Recommendation 1:
Managers should ensure that the audit of nursing care plans and reviews fully reflect the patients' risks, needs and goals in mental health aspects of care and involve patients in the process.

Recommendation 2:
Managers should ensure that there is dedicated clinical psychology input to the ward to support the development of psychological therapies and interventions across the staff and patient groups.

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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 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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