Mental Welfare Commission for Scotland

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

Date of visit: 27 August 2024

Where we visited

Bruar Ward is an eight-bedded, mixed-sex, locked rehabilitation unit for individuals, some of whom may have come to psychiatric services through contact via a forensic route.

We last visited this service in May 2023 and made recommendations that care plans should demonstrate patient involvement and, together with risk assessments, should have clear evidence of regular review.

The response we received from the service was that procedures had 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 to look into some concerns raised with the Commission.

Who we met with

We met with, and reviewed the care of six people, four of whom we met with in person and two whose care notes we reviewed.

We spoke with the service manager, the senior charge nurse, the associate nurse director, the occupational therapist and the consultant psychiatrist

Commission visitors

Dougie Seath, nursing officer

Justin McNicholl, social work officer

What people told us and what we found

During our visit we were keen to hear the views of individuals receiving care and treatment and to meet with staff who were providing input into the ward. We were also keen to know whether individuals felt part of their recovery journey, and equal partners in their care and treatment.

All of those that we spoke with had positive things to say about staff. Comments such as" non-judgemental", "helpful" and "sound" were mentioned. During this visit we found a good standard of recovery-focused care being delivered to individuals with varying and complex needs.

We noted there was a diverse range of mental health needs for the individuals in the ward. Many of the admissions have been for a number of years and due to the nature of their mental illness, there were challenges for staff to keep those in the ward motivated and engaged in activities. Despite this, we observed people being supported to participate in activities of daily living, as well as therapeutic, social, and recreational activities.

We met with the occupational therapist who has tried in his work to ensure activities are designed to the needs of individuals; he was optimistic that access to the social centre should increase in the coming months, providing more opportunities for the people in the ward.

Care, treatment, support and participation

Treatment was provided through a multidisciplinary team (MDT) model of care. We were told that this approach had greatly improved the level of engagement, with a focus upon individuals learning new skills through recreation and therapeutic interventions. The ward-based nursing team were supported by medical staff, an occupational therapist (OT), a psychologist and pharmacist.

We found individuals' records easy to navigate. There was a clear focus upon individuals' mental and physical well-being, as well as physical health assessments.

Individuals in Bruar Ward required continual assessment based upon their level of risk, which for a variety of reasons, could not be safely managed in less secure environments. We were pleased to see those risk assessments were reviewed regularly and amended as necessary to ensure individuals were provided with opportunities to spend time away from the ward and engage in community or hospital-based activities.

During our last visit to Bruar Ward, we were unable to see evidence of one-to-one engagement between staff and individuals. On this occasion, we were pleased to see recording of individual and staff engagement had significantly improved.

During our review of care records, we wanted to look at care plans and to see where individuals had participated in the process. It was good to note continued improvement in all aspects of care planning with a record of participation or an indication of why this could not be achieved. However, we found a number of reviews carried out which merely stated, "no change". We felt that there could have been more information provided as to why this was the case, and care plans reviewed to include more realistic goals.

Recommendation 1:
Managers should monitor care plan reviews to ensure adequate information is provided regarding non achievement of goals.

The multidisciplinary team (MDT) meets weekly to discuss everyone's progress. For some individuals, attending their weekly meeting may be difficult. Nevertheless, for those individuals, their views were sought, documented, and discussed prior to the meeting. The team recorded detailed discussions of every meeting in a locally designed form. We could clearly identify who had attended the meetings, and the actions and outcomes highlighted everyone's care, treatment and progress.

Although care records were quite bulky, they were easily accessible, with legal documents contained in a separate folder, including copies of Mental Health Act orders, consent to treatment forms (T2 and T3), high dose monitoring forms, specified person forms, Adults with Incapacity Act section 47 forms and copies of welfare guardianship powers together with reviews of one-to-one meetings with nursing staff. We felt that the files would be more manageable without copies of discontinued care plans and other historical material.

The Commission has published a good practice guide on care plans[1]. 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.

Multidisciplinary team (MDT)
The ward holds regular multidisciplinary team (MDT) meetings. These include psychiatry, nursing, pharmacy, occupational therapy and other professions as and when required. Each patient was discussed and reviewed at the weekly meeting.

Individuals that we spoke to reported that they were invited to the meetings and were kept well informed by the MDT.

Use of mental health and incapacity legislation

On the day of our visit, all individuals were subject to either the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act) or Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act) legislation. All documentation relating

[1] Person centred care plans good practice guide: https://www.mwcscot.org.uk/node/1203

to the Mental Health Act and Criminal Procedure Act was available in the files. The individuals we met with during our visit had a good understanding of their detained status, where they were subject to detention under the Acts.

Part 16 of the 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were all in place. However, we found a few cases of medications prescribed which were not legally authorised by the T3b form.

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

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; they are called a named person. Where an individual had nominated a named person, we found copies of this in the care record.

For those people that were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) we found copies of powers of attorney (POA) or guardianship certificates in the care records, with details of the POA or guardians clearly documented.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found each section 47 certificate had been completed correctly and, in most cases, had a comprehensive treatment plan accompanying it.

Rights and restrictions

Bruar Ward operates a locked door, commensurate with the level of risk identified for individuals in this type of care setting. Most individuals had unescorted time away from the ward, or regular escorted time, and this was reviewed regularly by the MDT. Some individuals that we spoke with would have preferred additional time away from the ward and told us that they struggled with the restrictions placed upon them as was required in this setting.

We noted that all individuals had access to independent advocacy. This service was offered by advocacy staff on an in-person basis, with individuals provided with opportunities to meet with advocacy at a time that was convenient for them.

Individuals could ask for support from advocacy for a range of issues or for support during mental health tribunal hearings. Equally, to ensure individuals had access to legal representation, nursing staff supported them to maintain contact with their legal advisor.

Mental health officers also provided support and guidance in relation to hearings, whether related to the Mental Health Act or criminal procedures matters.

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 specified person restrictions were in place under the Mental Health Act, we found all authorising paperwork was in place.

When we are reviewing individuals' records, we look 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 found evidence of advance statements available for everyone who had been supported to write one. We recognised for individuals who receive care and treatment in a rehabilitation setting it is important for them to document their views about the treatment they wish to receive. There was evidence of discussions with individuals to ensure any decisions that were made were fully understood by individuals and the care team.

The Commission has developed *Rights in Mind*[2]. 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.

Activity and occupation

Activities in rehabilitation wards are essential to ensure recovery planning that assists with re-integration into the community. We were pleased to hear from individuals and from our observations that occupational therapy (OT) provision for the ward is valued. This resource ensured that there was an offer of support and activities for all patients that promoted stimulation and social outlets.

We heard from some patients that the range and level of activities was good. Some patients in the ward accessed the social centre. This input was well regarded by both patients and staff. However, it was only available on a sessional basis and access to the gym was difficult and required staff supervision. We were informed that access

[2] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

was improving, and a greater use of the service should be available in the near future.

We noted that some individuals were reluctant to participate in some activities; despite this we saw successful efforts to engage them.

The physical environment

There were eight single en-suite rooms that were personalised, and individuals could have possessions to create a more homely feeling.

The ward was bright with communal spaces that were not too busy and quieter rooms where people could find some space to be on their own. The ward had direct access to a garden and there was also access to outdoor areas in the hospital grounds.

The bedrooms appeared homely though some were in need of re-decoration. The temperature of the ward was also mentioned as a problem, with windows unable to be opened in the hot weather. Also mentioned by those we spoke to and by staff, was ongoing surveillance of the water system, meaning that individuals and staff were having to drink bottled water.

Recommendation 3:
Managers should ensure that every effort is made to complete the water surveillance as quickly as possible.

Summary of recommendations

Recommendation 1:
Managers should monitor care plan reviews to ensure adequate information is provided regarding non achievement of goals.

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

Recommendation 3:
Managers should ensure that every effort is made to complete the water surveillance as quickly as possible.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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