Mental Welfare Commission for Scotland

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

Date of visit: 23 July 2024

Where we visited

Morlich Ward is a 12-bedded, mixed-sex unit providing inpatient hospital care for older adults experiencing complex functional mental illness other than dementia and, in addition, early-stage dementia. The ward supports those individuals whose care cannot be managed safely in community settings.

It is the only ward facility for the North Highland area, excluding Argyle and Bute. On the day of our visit there were no vacant beds.

We last visited this service in March 2022 and made recommendations for the audit of nursing care plan reviews and that recording of reviews were consistent across all care plans, that there was a system of auditing consent to treatment so that treatment given was legally authorised. The response we received from the service was that procedures would be put in place to ensure that the recommendations would be met in the set timescales.

On the day of this visit, we wanted to follow up on the previous recommendations and also to hear how patients and staff had settled back into the ward following a period where they had been decanted to allow anti-ligature work to be carried out.

We were also following up on intelligence gained from a complaint regarding issues around the standards of care in the ward.

Who we met with

We met with and reviewed the care of six individuals. We also met with one relative.

We spoke with the senior charge nurse (deputising), the nurse in charge, the associate nurse director and other nursing staff.

Due to the visit being unannounced we were unable to meet with senior charge nurse or service manager.

Commission visitors

Douglas Seath, nursing officer

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

The people we spoke with told us that nursing staff were approachable. Most individuals were able to tell us about their involvement in their care and treatment. We noted that the communication with families was good and that individuals felt involved in discussions about their care and treatment. Feedback about the staff team, from individuals and from relatives was positive.

We observed warm and respectful interactions between staff and individuals.

We found that discharge care plans were in place where appropriate. We also found evidence of one-to-one discussions with the individual and their named nurse.

We saw that physical health care needs were being addressed and followed up appropriately.

Care records

We viewed care plans and found that many were detailed, person-centred and holistic, covering a wide range of physical and mental health needs.

It was clear from the records that attention was paid to physical health needs, with liaison and input from other medical specialists as appropriate. There were a few care plans that were less detailed and concentrated more on physical health than mental health needs or where amalgamated physical and mental health needs were on one care plan.

There was also evidence of regular reviews of the care plans, however, the level of detail was variable in the review process, and we would have wanted this to be more consistent. We look forward to seeing improvement in this area when we next visit.

The daily notes contained detail including discussions with staff; overall, they showed evidence of individual involvement. This was supported by the record of views obtained by staff prior to the weekly review meeting, where decisions were made about discharge planning. In the individual files, detailed nursing and medical assessments had been completed at the point of admission and had been updated during the individual's journey, along with detailed risk assessment and risk management plans.

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.

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

Multidisciplinary team (MDT)
The unit has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy, and psychology staff, as well as social centre staff and an activity co-ordinator who attended for the MDT meeting. Referrals could be made to all other services as and when required.

We were told that there were four consultant psychiatrists for the ward and that there were four weekly MDT meetings. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and provide an update on their views. This also included the individual and their relatives/family.

Input to the MDT from pharmacy at the MDT meeting meant that good attention was given to the link between physical and mental health care in the individual records. Staff told us that individuals had regular access to allied health professionals, such as dietetics and physiotherapy, and we saw evidence of this on the day of our visit.

We asked the SCN about patients who were recorded as delayed discharge. We were told that there was an effective process and multi-agency working across the health and social care partnership for individuals who were delayed, and good links with the community mental health teams.

Use of mental health and incapacity legislation

On the day of our visit, 10 of the 12 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). The patients we met with during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act.

All documentation relating to detention under the Mental Health Act including certificates around capacity to consent to treatment, were in place in the files and were up-to-date.

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 in place where required and corresponded to the medication being prescribed. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date. However, not all were legally compliant, with medications prescribed but not authorised on the forms. More work needs to be done to ensure forms are legally compliant and could be improved by following the good practice found elsewhere in the service.

Recommendation 1:
Managers should put in place a system to ensure all Mental Health Act treatment certificates, including T2s and T3s, are in place and that all prescribed medication is legally authorised, where appropriate. As this is an issue that was noted on the last visit, this should be given priority.

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

For people who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act, 2000, (the AWI Act) we saw copies of the legal order in place apart from in one case, which we brought to the manager's attention. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan under s47 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, who has relevant powers and record this on the form. We found certificates present along with treatment plans for those who required them.

We saw do not attempt cardiopulmonary resuscitation (DNACPR) forms in files, and where DNACPR forms were in place we saw evidence of discussion and consultation with families and with the proxy decision makes where appropriate.

For individuals who were receiving covert medication, appropriate documentation was in place.

Rights and restrictions

Morlich Ward operated a locked door policy, commensurate with the level of risk identified with the individuals in the ward, due to the majority of those individuals being subject to detention. We were told that there were a few individuals, who due to their vulnerability and progression of their illness, would be at risk if the door was unlocked.

A notice explains this for visitors approaching for the first time. One person who was not detained said there was no difficulty in getting out of the ward. Individuals were aware of their rights and also how to contact advocacy services should they wish.

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

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

The unit had a dedicated activity co-ordinator and provided activities either on a one-to-one or group basis. We looked for evidence of activity planning in individual files to see that activities were linked to individual goals, recorded and evaluated.

Although we found this noted in the care plans, we found that the recording of activities was limited, and we heard from meeting individuals that they wanted to do more to keep themselves occupied.

There was no visual planner in place for individuals to know what and when activities were due to take place. However, individuals did tell us about how much they enjoyed their time out of the ward with the activity co-ordinator.

Recommendation 2:
Managers should make a programme of activities available on display in the ward so that individuals are aware of what is available daily.

The physical environment

Morlich Ward is a pleasant environment with all accommodation in single ensuite rooms.

The unit had a secure garden area that was well maintained and easily accessible. Individuals told us that they enjoyed the outdoor garden and that having their own rooms provided privacy.

The unit had an activity room, communal lounge and separate dining area and there were other seating areas throughout the unit, that offered a quieter space. There was a laundry room that enabled individuals to do their own washing while in hospital.

The unit has been upgraded as part of the anti-ligature programme in the hospital and we were told that most of the work had been carried out whilst they were decanted to another ward.

We did find some issues of concern with the environment. There were no manual or hydraulic hoist to help nurses to support individuals who required assistance with bathing. There were also only overhead showers in the en-suite bathrooms; this would not help individuals who needed assistance and a hose-type fitting would be more appropriate. Finally, the lighting controls in the bedrooms were overly complicated for individuals in this age range to manage.

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

Recommendation 3:
Managers should arrange to provide the necessary equipment and make alterations to ensure the environment is suitable for older adults.

Any other comments

Although the ward was designated as an older adult functional assessment unit, there were individuals in the ward on the day of the visit who had diagnoses of dementia or learning disability and some who were well under 65 years of age with diagnosis of functional illness.

This was clearly putting additional pressure on nursing staff to meet such a wide range of needs within the current environment.

Recommendation 4:
Managers should review the bed capacity and designation in each specialty to better meet the needs of the individuals being referred.

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. 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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