Mental Welfare Commission for Scotland

Report on announced visit to:

Aonach Mor, New Craigs Hospital, Benula Road, Inverness IV3 8EL

Date of visit: 10 August 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

We last visited Aonach Mor in September 2019, before the start of the pandemic. This local visit was undertaken using in-person interviews with patients and staff on site.

Aonach Mor is a 14-bedded rehabilitation unit divided into three separate flats located in a suburb of Inverness; 12 beds currently occupied. The flats are self-contained but all are similar in layout and are mixed sex with no distinction in terms of function. Aonach Mor staff provide assistance with building practical skills related to independent living and education regarding their mental and physical wellbeing towards recovery. Group work plays a significant part in this process but one-to-one sessions have been used more frequently during the pandemic. These are individually tailored to patients needs and provided by nurses and occupational therapists (OTs). On our last visit we made no recommendations.

On this occasion, we wanted to look at how the service was managing the return to more normal practices and the impact that restrictions have had during the pandemic on private/family life during this period.

Who we met with

We met with and reviewed the care and treatment of six patients.

We spoke with the service manager, the charge nurse, consultant psychiatrist and other nursing staff.

Commission visitors

Douglas Seath, nursing officer

Anne Craig, social work officer

What people told us and what we found

Care, treatment, support and participation

We met with a number of patients who told us that they were happy in the unit, felt well supported and they appeared settled and relaxed in their environment. We observed supportive interactions between nursing staff and patients during our visit. There was clear evidence that the patients were knowledgeable about their illness, and their rehabilitation programme. They described being actively involved in their treatment and rehabilitation, highlighting the development of life skills, and a variety of activities that were tailored to their individual needs. We noted that the service also provides information and signposts patients to access local organisations and activities, and community centres. Both patients and staff discussed that the pandemic had impacted on this level of engagement in the local community, but they were looking to slowly re-engage.

We saw detailed nursing assessment documentation in patient files which gave a good account of the patient's background and current circumstances. There were also risk assessments followed by more detailed management plans and these were clear and easy to find. We also found evidence that one-to-one meetings with nursing staff were being carried out; although these were generally recorded, clearer highlighting of these interactions would be beneficial.

All the care plans we reviewed were person-centred and provided an accurate reflection of the care delivered. There were detailed in relation to both physical and mental health needs, covering all the main areas in a supportive and informative way and they were regularly reviewed. Chronological notes were detailed and it was clear that the staff team were providing person-centred care and knew their patients, and their families, very well.

There was evidence of regular multidisciplinary meetings (MDT) with attendance from the members of the multidisciplinary team, depending on the needs of the individual patient. Notably, there is a pharmacist in regular attendance in the unit. The quality of the recording of these meetings, which are fundamental to the patient progress, was detailed with clear recordings of patient views and a summary of future plans.

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

Use of mental health and incapacity legislation

On the day of our visit, we reviewed those patients in the ward who were subject to care and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003, (the Mental Health Act). We reviewed the legal authority for ongoing care and treatment for patients in this service and found all the required statutory paperwork to be in place. We looked at consent to treatment certificates (T2) and certificates authorising treatment (T3) for all patients who required these and found one where a newly prescribed medication on a T2 form was done without appropriate authorisation in place. We spoke to staff on the day who agreed to take the necessary steps to amend this.

Sections 281-286 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 these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and the need for those special restrictions to be regularly reviewed. Responsible medical officers have to complete certain forms in relation to specified persons. We saw that the necessary notification forms were in place where this was appropriate. We saw that reasoned opinions were recorded by doctors relating to specified persons decisions but that specific restrictions which were being applied were not always clearly documented in the file. We discussed further with staff some individual cases in relation to specified person procedures.

Section 47 of the Adults with Incapacity Act (the AWI Act) authorises medical treatment for people who are unable to give consent. Under section 47 of the AWI Act a doctor, (or another health care professional who has undertaken specific training) examines the person and, where the individual is assessed as lacking capacity to consent, issues a certificate of incapacity. We found two patients who, due to reduced capacity to consent, should have had their treatment authorised in this way but had no certificate. They were also being assessed for suitability for welfare guardianship under the AWI Act.

Recommendation 1:
Managers should ensure that the reason for placing restrictions on patients in the form of specified person is clearly documented.

Recommendation 2:
Managers should ensure that s47 treatment plans are completed, available and correctly filed in accordance with the AWI Act Code of Practice (third edition).

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

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

There was a strong emphasis on rehabilitation, supporting individuals referred from the hospital ward environment into Aonach Mor and on into independent living. We found good evidence of nursing staff and occupational therapists providing a range of inputs, including skills development and in facilitating activities both on and off the unit. Each patient was encouraged to budget and cook for themselves, according to their level of skill, with assistance provided if necessary. There was a broad range of varied activities with programmes designed around rehabilitation. There were also social outings both escorted and unescorted to give patients opportunities to develop skills in this area and to expand their social networks prior to discharge. These activities were clearly documented.

Covid-19 has had a significant impact on the community links, which to date have played such an important part in preparing patients for discharge. We were pleased to hear that these links are beginning to recover. We look forward to hearing how this progresses over the coming months.

The physical environment

The unit was in fairly good decorative order, though in need of some painting which we were told is due to start in the near future. The kitchen appeared well provided, and was clean and tidy with storage space in cupboards and fridge for each patient. There was a large garden to the rear, which also provided some occupation with cultivation of vegetables and flowers.

Any other comments

The clinical area manager discussed with us the Royal College of Psychiatrists Standards for Inpatients in mental health rehabilitation services. This was one of the recommendations noted in the Commission's report into rehabilitation services**.** This report can be found at: https://www.mwcscot.org.uk/node/1394

The approach is well recognised, rigorous with supportive quality assurance and is an accreditation process for mental health services. The service, in preparing to seek accreditation, is at present reviewing all their systems and practice and benchmarking against respective standards. We look forward to hearing about the development of this project and its impact on improving patient care.

However, it did appear that some recent referrals to the service may have led to premature or inappropriate admissions, possibly due to pressure on adult acute wards, and who were clearly out with the normal criteria for admission to a rehabilitation ward. This can have an impact on the ability of nurses to carry put their normal duties with other patients and impact on care and treatment of the remaining patients. In the light of events, it may be timely for managers to review admission protocols in the light of this.

Recommendation 3:
Managers should review the admission protocol for the ward to ensure patients who meet the criteria for rehabilitation are admitted to the ward.

Summary of recommendations

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Recommendation 2:
Managers should ensure that s47 treatment plans are completed, available and correctly filed in accordance with the AWI Act Code of Practice (third edition).

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Service response to recommendations

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