**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:**

Affric Ward, New Craigs Hospital, Leachkin Road, Inverness, IV3 8NP

**Date of visit:** 11 June 2024

## Where we visited

Affric ward is a 10-bedded intensive psychiatric care unit (IPCU) situated in the main building in New Craigs Hospital. An IPCU provides intensive treatment and interventions to individuals who present an increased level of clinical risk and require a more intensive level of observation. IPCUs generally have a higher ratio of staff and a locked door. It would be expected that staff working in IPCUs have skills and experience in caring for acutely ill and often distressed individuals. Individuals can either be admitted following a referral from a general adult psychiatrist, transferred from prison due to mental ill health or admitted from the courts due to criminal offending behaviour.

We last visited this service in March 2023, and made recommendations about care plans being person-centred and demonstrating involvement with evidence of goal setting, interventions and review; we also recommended auditing consent to treatment forms and the level of activities. The response we received from the service was that procedures had been introduced to bring about improvements in these areas.

On the day of this visit, we wanted to follow up on the previous recommendations and meet with individuals, relatives/carers and staff to hear their views and experiences on how care and treatment was being provided on the ward.

## Who we met with

As this visit was unannounced, we were unsure if we would have the opportunity to speak with individuals and relatives. However, we were able to speak with and review the care of seven people, and reviewed the care notes of one other.

We also discussed the care and treatment of two individuals with their relatives.

We spoke with the hospital manager, the senior charge nurse, the nurse director, clinical director and consultant psychiatrist.

## Commission visitors

Douglas Seath, nursing officer

Gemma Maguire, social work officer

## What people told us and what we found

The individuals we met on the day of the visit were mainly positive about their care and treatment in Affric Ward. Their feedback included their views about being treated with respect and staff having regard for privacy. Some told us that they had a named nurse who they met with regularly and that they valued this one-to-one interaction. Others were unaware of who their named nurse was.

All of those we met with told us that they had regular contact with medical staff and that there was a regular review of their physical and mental health care needs. Many spoke highly of the activity co-ordinator and activities that were available on the ward. This has been a new post that has been created since our last visit. There is also a dedicated space for relatives to meet their family member privately.

Some individuals told us that they were unhappy being in hospital while others told us about restrictions that were in place and that they were not happy about, such as a lack of access to their mobile telephone. This restriction applied to all individuals at the time of our visit, although they could check messages once daily or use their mobile while out of the ward by arrangement. After discussion with the senior charge nurse (SCN), we were informed that this policy is under review and that, other than where there is a risk identified, in future most of the individuals admitted will have possession of their mobile phones.

Some people told us that they felt there were gaps in their care plan in relation to opportunities to engage with an OT. One person told us that they wanted to develop skills in cooking and use the OT therapy kitchen in the ward, however there was no OT based in the ward and no access to the therapy kitchen.

## Care, treatment, support and participation

Nursing care plans are a tool that set out how care should be delivered while the individual is on the ward; best practice would be for effective care plans to be in place, to provide consistency and continuity of care and treatment. They should also be regularly reviewed to provide a record of progress that has been made.

We found evidence of person-centred care plans and regular reviews taking place. Some of the reviews provided a good level of detail on the progress that had been made and identified areas of care that required ongoing support. A few reviews did not record detailed information about the specific nursing interventions and the individuals progress in relation to the goals set.

We found the risk assessments to be comprehensive and of a good standard. However, the forms were not always signed and dated appropriately in line with optimal record keeping.

### Care records

We found a number of examples of care records that recorded comprehensive and personalised information that included psychological, physical and emotional aspects of health. The care plans were regularly reviewed though not always signed, as many individuals were too unwell to do this. These records continue to be provided in paper format and there appears to be no plan to move to an electronic record. Some of the files were very bulky with

documents loose and occasionally misplaced. There was no administrative support to staff to ensure files were kept in order.

We saw evidence of one-to-one interventions between nursing staff and individuals in their care. The recording of the one-to-one interventions were detailed, regular and included information on the individuals' views in relation to their care and treatment.

We were pleased to see comprehensive care recording from various members of the multidisciplinary team. In particular, the care records from medical staff were of a high standard. We were impressed by the regular review of individual's mental health by the consultant psychiatrist and other doctors in their final years of speciality training. The care records we reviewed were thorough, person-centred and evidenced a rights-based approach.

We noted the high levels of clinical acuity in the ward and could see where individuals required intensive treatment, interventions and high levels of engagement. Individuals could experience high levels of stress and distress leading to increased clinical risk, often associated with higher levels of verbal and physical aggression and self-harm. We were pleased to note that the multidisciplinary team were actively involved in providing the support, care and treatment to individuals at these times.

### Multidisciplinary team (MDT)

The multidisciplinary team (MDT) meeting was held weekly in the ward. In attendance at the meetings were mainly medical and nursing staff with others such as social work and community psychiatric nurse attending by invitation. Individuals were given the opportunity to attend, however the record did not identify the names of those at each meeting, so it was hard to tell who attended each time.

The MDT meeting was recorded on a mental health structured MDT meeting template. The template had headings relevant to the care and treatment of the patients in Affric Ward. We found comprehensive and detailed recording of the MDT discussion and decisions that promoted a holistic approach to each individual's care. There was evidence of discharge planning for some of the people whose care we reviewed. For these individuals, there had been communication with community teams and services to support discharge planning.

There was no dedicated clinical psychology service based in the ward. We were told that when psychology input was required, a referral had to be made to the general adult clinical psychology services.

We were also informed that if occupational therapy (OT) input was required, a referral should be made to the OT adult acute services. We heard that this arrangement had been problematic, mainly due to the associated risks factors for individuals who meet the criteria for IPCU having to leave the ward to attend. The nurses told us that when the OT was integrated into the MDT, there was a greater understanding of the patient's needs and assessed risks factors. We heard from some individuals that they thought they would benefit from regular OT involvement, especially in relation to developing cooking skills and having access to a therapy kitchen in the ward.

In relation to carer/relative involvement, we heard and saw that when family were involved with someone's care, separate family meetings were arranged.

**Recommendation 1:**
Managers should review the occupational therapy provision in Affric Ward to ensure greater equity of occupational therapy provision across the hospital and provide a more integrated assessment of individual skills.

**Recommendation 2:**
Managers should address the inequitable access to psychological therapies for individuals in the IPCU, ensuring that they are afforded an appropriate service at the time of need.

**Recommendation 3:**
Managers should address the security and good order of record keeping in paper files so that notes are accurate, accessible and durable.

## Use of mental health and incapacity legislation

On the day of our visit, all 10 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). We found the forms relating to each person's detention in a dedicated section of the record.

Those we met with during our visit had a good understanding of their detention status under the Mental Health Act. Some people we met with had a limited understanding of their rights. However, we were pleased to note from the files that we viewed that there was evidence of legal representation and advocacy involvement to support individuals in an understanding of their legal status and their ability to exercise their rights.

Part 16 (sections 235 to 248) of the Mental Health Act sets out conditions under which treatment may be given to detained individuals who are either capable or incapable of consenting to specific treatments. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments and the authorisation of medications prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 if the person is consenting. All relevant forms were present, were legally authorised and in date.

Medication was recorded on the electronic prescribing system HEPMA (hospital electronic prescribing and medicines administration). T2 and T3 certificates authorising treatment were stored separately in a folder.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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 is recorded the form.

We found that AWI Act forms for welfare guardianship, and section 47 certificates for authorisation of treatment were present. However, a power of attorney form listing the powers of the proxy for one person was missing.

## Rights and restrictions

Affric Ward continues to operate a locked door, commensurate with the level of risk identified with this group of individuals. Most of those we met with had good knowledge of their rights. We saw that each person detained under the Mental Health Act received a letter from medical records that included information on their detained status and their rights in relation to this. We found that some people had exercised their rights and appealed their detention.

When we are reviewing files, 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 do or do not want. Health boards have a responsibility for promoting advance statements. We found one advance statement in the files we reviewed, although it was several years old. It was evident from the review of individual files and during our discussions that some people were not at a point in their recovery to be able to make decisions regarding their care and treatment.

We were told that advocacy was available regularly in the ward through Highland Advocacy. We were advised that advocacy would attend the ward on request and provided a good service to those who wished to engage with them. We were pleased that all the individuals we met with on the day of the visit either had in place, or had been offered, advocacy support.

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. None of the individuals in the ward were specified at the time of our visit.

Some individuals told us that they were unhappy about their mobile telephones being removed and when we spoke with staff, they told us that all individuals' phones were removed when they were admitted to the ward under the unit's policy. We asked for more detail about this and were told that there was a blanket restriction policy, which covered the removal of mobile telephones and other such items.

We did not find individual risk assessments in place for such restrictions or the appropriate legal authority that we would have expected to see. Mobile phones could be used under supervision to check for messages once per day or when out of the ward under escort. Individuals could still make phone calls on request, but from the landline in the nursing station, a situation which afforded little privacy.

In relation to this type of restriction, the Commission has good practice guidance on specified persons, and it is available on our website at https://www.mwcscot.org.uk/node/512

**Recommendation 4:**
Managers should ensure that where restrictions are placed upon an individual, these should be proportionate, reasonable and justifiable, ensuring appropriate legal frameworks are in place to authorise such measures under the Mental Health Act. The policy of removing mobile phones for all individuals should be reviewed and a copy of its replacement sent to the Commission.

The Commission has also developed a *Rights in Mind* pathway. This pathway is designed to help staff in mental health services ensure that individuals 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 heard and found evidence of a broad range of activities that were available for people in Affric Ward. This was a significant improvement since our previous visit. The activity and occupation in the ward were mainly provided by the activities co-ordinator and nursing staff with sessional input from the social centre. There was limited access to the gym and only an exercise bike on the ward. However, there were plans to introduce an outdoor gym in the garden area which would be a valuable addition to current provision.

The activities available included art therapy, music group, arts and crafts, creative sessions, and were geared to the specific interests of the people in the ward at the time. We heard some people attended the social centre, an activity resource situated in the grounds of the hospital. This was only available for one session each week.

## The physical environment

Affric Ward is a mixed-sex IPCU, therefore the physical environment had to be managed to support patients to feel safe and comfortable in the ward setting. It had furnishings appropriate to the needs of the people there. The access to fresh air was problematic due to windows being locked, as advised by the Health and Safety Executive for reasons of ligature risk.

The bedroom space in the ward was divided into a male and female area. Each bedroom had en-suite facilities and we heard, and saw, that individuals could personalise their room if they choose to. The cleanliness of the ward was of a high standard. The ward had a range of spaces available to use, such as a lounge, dining area, kitchen and an activity and games room.

There was a courtyard garden area that was available for people to spend time in. Access to this area was supervised throughout the day and until late evening. We heard that there is a plan to develop gardening in the courtyard. The intention is to refurbish the garden area with planters containing flowers, herbs and vegetables planted by people in the ward. As well as providing therapeutic benefits to those who engaged in gardening, the refurbishment of the courtyard would provide a pleasant and relaxing space for people to enjoy. We especially liked the large-scale mural of Glen Affric in place, concealing the perimeter wall and creating the illusion of being out in the countryside. The furnishings however, were in a poor state and in need of refurbishment or replacement

**Recommendation 5:**
Managers should assess the safety of the garden furniture and prioritise replacement which would also be of benefit to the mental health of individuals in the ward.

## Summary of recommendations

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Managers should review the occupational therapy provision in Affric Ward to ensure greater equity of occupational therapy provision across the hospital and provide a more integrated assessment of individual skills.

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**Recommendation 5:**
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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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