**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Muirton Ward, Seafield Hospital, Buckie, AB56 1EJ

**Date of visit:** 11 July 2024

## Where we visited

Muirton Ward is an older adult assessment unit for people with dementia located in the town of Buckie on the Moray coast. Individuals can be admitted directly to this ward or transferred following an initial admission to the mental health unit at Dr Gray's Hospital.

The ward has eight beds and on the day of our visit, the ward was full. All individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Since our last visit, the senior charge nurse (SCN) told us that there had been occasions where the ward has had to use the surge beds, due to the mental health unit at Dr Gray's Hospital being at full capacity. We were told that there were currently two individuals who were boarding from Dr Gray's Hospital, and that those individuals did not have a diagnosis of dementia but had a diagnosis of a functional illness.

We last visited this service in June 2023 and made a recommendation for the service to consider recruiting an activity nurse. We received an action plan from the service and were satisfied with the response. The service had intended to look at employing an activity therapist, however we were told that due to financial constraints this has not progressed.

On the day of this visit we wanted to follow up on the previous recommendation and see how the service was carrying out activity provision to the individuals in the ward. We also wanted to speak with individuals, relatives and staff.

### Who we met with

We met with three individuals, reviewed the care of four individuals and spoke with three relatives.

We spoke with ward-based staff and the senior charge nurse (SCN).

In addition to this, we made contact with the local advocacy service.

### Commission visitors

Tracey Ferguson, social work officer

Susan Tait, nursing officer

## What people told us and what we found

There were individuals in the ward who had recently been admitted and others who had been assessed and were waiting on the next stage of their journey. We introduced ourselves to all individuals in the ward and where we were able to have a more in-depth discussion with some, the feedback we heard about staffing was positive. We were told that the staff were “experienced”, “good” and “caring”.

We spoke to a few individuals who were unhappy at being in the ward and we wanted to ensure that those individuals were being supported with their rights; we were satisfied that they were.

The relatives we spoke with described staff as “lovely” and “approachable”. We spoke to a relative who told us that they felt very involved in their relative’s care and that they continued to receive regular updates following the multidisciplinary team (MDT) meetings and when they visited the ward. However, we heard from another set of relatives where their experience was not the same. They told us that they did not feel involved and did not receive updates. We had a further discussion with the SCN about this and were made aware that the service had received a complaint, which we will follow this up with managers.

From our observations on the ward, there was a relaxed atmosphere, and individuals appeared settled. There was ample space for individuals to sit with others or space that offered privacy. The ward was an older style unit that had plenty of space for individuals to move around easily, which is what we saw on the day of the visit. We observed staff responding in a supportive and calm manner where an individual was experiencing stress/distress behaviours.

From speaking to the ward staff, we gained a sense that they knew the individuals well and were able to provide us with an update in relation to people’s care and treatment, which was similar to what we found on our previous visit.

The ward had an information pack that was given to relatives following admission of their family member. This pack provided relatives with detailed information that covered a wide range of topics, such as carer support, individual rights, visiting times, laundry arrangements and discharge planning.

We asked the SCN about stress and distress training as we were previously made aware that some staff had undergoing this training but had since left, only leaving one nurse who had undergone the training. We were told that there was no regular stress/distress training for staff and that the service did not have the infrastructure and support from psychology to promote this model effectively.

The SCN told us about the ongoing recruitment plans for nursing staff and that by September, all the vacant nursing posts would be filled, resulting in a full

complement of a staff team. The staffing complement will include 10 staff nurses, and some of those will be newly qualified nurses.

## Care, treatment, support and participation

From the individual files we reviewed, there was a completed SBAR (situation, background, assessment and recommendation) document that provided a detailed account of the individual's history and the circumstances that led to the admission, along with the next steps that were required to support the individual in their journey.

In each file, we saw the 'getting to know me' booklet that had been completed by individuals and/or relatives and most gave a good account of the person's life history, including their likes and dislikes. Where 'do not attempt cardiopulmonary resuscitation' (DNACPR) documents were in place, they appeared appropriate and recorded that the proxy or nearest relative had been consulted.

The ward continues to have a named nurse system in place, and we saw nursing and risk assessments that were detailed and completed on admission. However, we found that the risk management plans lacked review and saw that for some individuals who had been in the ward for a longer period of time, their plan had never been reviewed or updated. We asked the SCN about the review process and were told that identified risks were incorporated into the individual's recovery plan and those recovery plans were reviewed regularly. We are aware that identified risks for this population may differ due to the progression of their organic illness and associated physical health care. However, given that the ward was also admitting individuals with a functional mental illness, who may present with different risks, we felt there was not a clear process in place with regards to assessing and reviewing risks. We provided an example of an individual's care, where the risk of suicide was assessed on admission and the risk management plan identified how the staff were going to manage this risk. The level of risk had changed and was reflected in other documents, but the risk assessment/risk management plan had not been updated or changed to reflect this.

We are aware from other local visits, that NHS Grampian has done work around their care planning process and documentation, that includes a new audit tool. We were told that this had not been rolled out to Muirton Ward or other inpatient settings in Moray, and managers were unsure if this would be.

We found evidence of detailed, person-centred care plans that addressed the mental health and physical health needs of the individual with evidence of care plans being reviewed and updated where necessary. We did have a discussion with the staff about the importance of updating and reviewing care plans following review, as we found a few where it would appear that the care plan still related to the assessment stage, despite a review having taken place. There was variation in the level of information provided in the stress/distress care plans, with some that had detailed

information about triggers and how to manage these behaviours; we found a few where this information was missing. Most of them included a meaningful evaluation, although this varied, as did the evidence around individual and family participation.

The SCN told us that they continued to carry out regular audits and that any actions for these audits were addressed. We suggested that the SCN linked in with other services across Grampian where the new format was being applied, to see if the current audit tool that was being used in Muirton Ward needed to be revised, to enhance the overall quality of care planning.

We found there was a good care plan in place that covered the individual's legal status, including the information they had received, and their rights explained.

Where covert medication pathways were in place, we saw appropriate documentation, including detailed reasons for the need to use this, along with appropriate review.

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.

**Recommendation 1:**
Managers must ensure that there is a process in place to review risk assessment and risk management plans.

**Care records**
Individual nursing care records were in paper format, and each file was organised with separated sections for information; we found the files were easy to navigate.

We were advised that the prescription Kardex's had recently moved to the electronic system, HePMA and that the consultant psychiatrists were using TRAKCare. Although we were told this, on reviewing records we found that the consultants were not entering information onto this system, but their written documents were being scanned onto C-cube, a part of the TRAK system. Administration staff scan the clinician's daily documents onto this system, where documents were stored in a 'year' and not by date.

We heard from nursing staff that this was a challenge for them getting updates when they returned from leave, as it could be difficult to find the notes.

We heard from managers that they had concerns about the different recording systems and the risk of not having all records held in one place. We also found this to be the case on the day of our visit.

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

We continue to hear about the plans for NHS Grampian to move to a new electronic system and were told that there are ongoing pilot sites testing the system across Grampian; these are mainly in Royal Cornhill Hospital. There was no planned date for this to be rolled out to all services as yet, but when this does happen, it should create the opportunity for all records to become integrated.

**Multidisciplinary team (MDT)**
There continued to be two consultant psychiatrists that covered the ward, and we were told that MDT meetings take place weekly. We were told that individuals in the ward continued to access allied health professional (AHPs) and psychological services via a referral system.

We noted that there were several individuals in the ward who would have benefitted from psychology input due to their complex presentations. Psychology input is a crucial part of individuals care and treatment and we found that no one in the ward had a psychological formulation to support the management of stressed/distressed behaviours.

**Recommendations 2:**
Managers must ensure that the unit has dedicated psychology input to inform care and treatment and aid individuals' recovery and rehabilitation.

There was no specific training or supervision for staff and while there was recorded evidence of the use of non-pharmacological interventions to support individuals with stressed/distressed behaviours, we found that there was a lack of input or no consideration of input for this.

We found there was a focus on the link between physical and mental health care in the individual's records, along with regular physical healthcare monitoring.

The weekly MDT meeting documents that we reviewed recorded who was present at the meeting, along with each individual's updates/progress, completed by nursing staff, along with the recorded action/outcomes from the meeting.

We were told that individuals and relatives did not attend the weekly meeting, however there were MDT meetings arranged for them at regular intervals throughout the admission, and as part of discharge planning. The MDT meeting record that the nursing staff completed had a section for who was responsible to update the relative after the meeting. Whilst most of these sections were completed, we found one where there was no recording and it was unclear if the relative had been updated and informed of the changes.

It was difficult to see from reviewing the consultant psychiatrist records as to when they reviewed individuals' care and treatment, including their detention status. We found that this was not always clearly evidenced in the MDT meeting records which

were then uploaded to the electronic system. We suggested to managers that this element could be incorporated into the MDT meeting document completed by nursing staff.

The SCN told us that there continued to be weekly contact with social work to discuss and receive updates on the progress of discharge planning and we found evidence of this in individuals' files. What was concerning to see was that many of the records we reviewed had 'no update'.

We discussed one case with the SCN where there had been adult protection activity; it was unclear from reviewing the notes what the outcome of this was, as there was no specific recording in the daily notes or the social work contact record. We discussed another case where staff were unaware if social work had completed an assessment to indicate next steps. We advised them that this assessment was a crucial part of discharge planning.

We were told that although the ward put in place ways to get updates from social work, this did not appear to be working well, as progress was slow, or staff received 'no updates'. We found this lack of update/progress concerning and we heard that staff continued to try to obtain updates, twice weekly however, this was clearly not working.

**Recommendation 3:**
Managers in the Moray HSCP must review the current system in place for receiving input and updates from community staff as part of discharge planning process.

## Use of mental health and incapacity legislation

On the day of our visit, eight individuals were detained under the Mental Health Act. We reviewed the legal documentation available in the files and found that all Mental Health Act paperwork was in order.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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, although we were concerned to find that almost all individuals were being prescribed medication without the correct legal authority being in place.

We checked the consent to treatment certificates along with the hospital electronic prescribing and medicines administration system (HePMA) and shared concerns with the SCN on the day. We requested that the SCN urgently follow this up with medical staff on the day of our visit. We followed this up with managers and were advised that the discrepancies were corrected.

**Recommendation 4:**
Managers, medical and nursing staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular auditing compliance with this should be put in place.

We were told that there was no mental health pharmacist attached to Muirton Ward.

Since our last visit the SCN informed us that the use of intramuscular medication (IM) had not been administered or prescribed for individuals who had not been detained under the Mental Health Act. The SCN told us about the process that was in place if there were concerns about an individual's presentation. We were told that the individual would be assessed by a doctor if there was consideration of using Mental Health Act legislation.

For individuals who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act), we saw a copy of the legal order in place, such as power of attorney and welfare guardianship orders.

The ward had a display board in the staff office that provided an overview of all individuals in the ward and recorded their legal status. We were pleased to see that this board clearly recorded the specific section of the AWI Act on the board, along with other essential information.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan 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, who has relevant powers and record this on the form.

We found that most s47 certificates were detailed and completed in accordance with the AWI Act code of practice for medical practitioners, however treatment plans varied.

## Rights and restrictions

The ward had a locked door policy in place that was commensurate with the level of risk identified with this group of people. The ward continued to have good links with Circles Network advocacy service, who regularly visited, supporting individuals with their rights. We were pleased to note that the ward had the Commission's 'Rights in Mind' pathway displayed on the wall in the corridor and in the relatives' information pack.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are

introduced, it is important that the principle of least restriction is applied. No one was subject to specified person legislation on the day of this visit.

When we are reviewing individual 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 did not find any advance statements, but this was due to the advanced stages of illness for most of the individuals on the ward.

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

We wanted to follow up on our recommendation about activities made on our last visit.

The ward did not have a dedicated activity co-ordinator/therapist to support the planning and to help co-ordinate group or one-to-one activities. We have continued to share our concerns from the previous visit about the lack of regular activities taking place for individuals. We made the recommendation last year for the managers of Moray HSCP to consider recruiting an activity therapist; we were told that due to financial constraints, the HSCP could not progress this and we were advised that each day, a healthcare support worker (HCSW) would plan the activities for that day.

On this visit, we saw more evidence of activities taking place and the HCSW recorded these separately in an activity folder. The ward had a new activity board that identified which activities were happening on each day. While the activity was being recorded for individuals, there was no link to the benefit of this for the individual and no link to the management of some individuals stressed/distressed behaviours.

We noted that a record was kept of when a person was not able to engage in the group activities due to their presentation, however no alternatives were offered. The recording of family visits was often noted as the only activity on that day.

There was a separate activity room at the far end of the ward although activities tended to happen in the lounge/dining area. We saw some improvement from our last visit with regards to activity provision, however a few individuals told us that

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

there was not enough to do to keep them occupied, and we found that people wanted to engage in more activities.

Therapeutic activities are important to support individuals with their stressed/distressed symptoms and again, we continued to hear from staff about the benefit and focus of activities. We were told that activities still depended on other clinical activity across the ward, even with a designated HCSW leading the activity for each day. Therefore, we will repeat the recommendation from last year.

**Recommendation 5:**
Managers must consider the appointment of a dedicated activity therapist to ensure the provision of both individual and group activities across the ward.

## The physical environment

This ward was an older-style dormer ward that was spacious, with a corridor that led to single rooms and shared dormitories. Each dormitory had access to a shower room and toilet.

The ward had a dining/lounge area, with access through to a large conservatory.

There was a television displayed on the wall in the lounge. There were ample sitting areas and another quiet lounge, where visitors could meet with their relatives in privacy. There was space for individuals to walk freely up the large corridor area.

The ward had an enclosed garden area that we were told individuals and relatives used, particularly on days when the weather was good.

There was some dementia friendly signage on display throughout the ward, which helped people to find their way around the ward, however we felt that this would benefit from a review and update.

When we last visited last, we were aware that there were ongoing discussions with Moray HSCP and NHS Grampian in relation to works that were required to be undertaken at Ward 4, Dr Gray's Hospital. At that time there was a plan being considered for Muirton Ward to decant to another area in the main Seafield hospital, and because of this, improvement works at Muirton Ward had been put on hold.

We have continued to receive updates from the Chief Officer of Moray HSCP and have been told that there are currently no plans to decant Muirton Ward, as there are further decisions to be made about Ward 4, the mental health unit at Dr Gray's.

We suggested to managers that it may be prudent to consider undertaking an environmental assessment of Muirton Ward to ensure it meets the needs of the people with dementia.

## Summary of recommendations

**Recommendation 1:**
Managers must ensure there is a process put in place to review risk assessment and risk management plans.

**Recommendations 2:**
Managers must ensure that the unit has dedicated psychology input to inform care and treatment and aid individuals' recovery and rehabilitation.

**Recommendation 3:**
Managers in the Moray HSCP must review the current system in place for receiving input and updates from community staff as part of discharge planning.

**Recommendation 4:**
Managers, medical and nursing staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular auditing compliance with this should be put in place.

**Recommendation 5:**
Managers must consider the appointment of a dedicated activity therapist to ensure the provision of both individual and group activities across the ward.

## 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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