Mental Welfare Commission for Scotland

Report on an announced visit to: New Craigs Hospital, Bruar Rehabilitation Ward, Leachkin Road, Inverness, IV3 8NP and Aonach Mhor Rehabilitation Unit, 120 Benula Road, Inverness, IV3 8EL

Date of visit: 17 March 2016

Where we visited

Bruar Ward is an eight bedded, mixed sex, locked, rehabilitation unit for patients, often with a forensic presentation, set within the grounds of New Craigs Hospital.

Aonach Mhor is a 14 bedded community rehabilitation unit. The unit has three self-functioning wings, each with its own sitting-room/kitchen and utility room. There is one central office and clinical room. A Community Rehabilitation Team, or Aonach Mhor staff, offer a six week transitional support package for individuals following discharge.

We last visited these wards on 11 February 2015 and made a recommendation about ensuring that there was a reasoned opinion for all patients subject to being a specified person.

On the day of this visit we wanted to follow up on the previous recommendation.

Who we met with

We met with six patients and reviewed their notes. We reviewed the notes of two other individuals. No carers, relatives or friends were available on the day of this visit.

We also spoke with the charge nurses and the Hospital Nurse Manager.

Commission visitors

Tony Jevon, Social Work Officer (coordinator)

Ian Cairns, Social Work Officer.

What people told us and what we found

Care, treatment, support and participation

Individuals we spoke with on the day were very complimentary about the treatment provided in the rehabilitation service by both medical and nursing staff and they told us they were treated with respect. Individuals seen on the visit did not raise any significant issues about their current care and treatment in either of the rehabilitation units.

Individuals seen told us they were involved in their care plans. The care plans were recovery focussed and signed by the individual concerned. Care plans were reviewed both in the weekly team meetings and in regular Care Programme Approach meetings, and there was clear evidence of input from a multi-disciplinary team that included, as well as doctors and nurses, occupational therapists and social workers. A pharmacist also attends ward rounds.

We found good evidence of occupational therapists (OT's) providing a range of inputs including skills development and facilitating activities on and off the units. We also saw OTs completing outcome star action plans with individuals, detailing recovery focussed inputs and actions. Each individual had a "My physical health" booklet completed, focussing on maintaining good physical health and regular check-ups.

A new personal recovery care plan was being piloted in the units. We were asked for feedback on how these care plans were being used. We looked in detail at some examples and gave some feedback which included: that the objectives and the actions needed to be more clearly differentiated, the actions needed to be numbered so that they could be referenced in the reviews, and the review ought to comment on progress made with each action. Training may be necessary for staff if these are to be introduced more widely.

Use of mental health and incapacity legislation

Most people seen were detained under the mental health act; they knew about their rights, had been given information about the Mental Health Tribunal, or had been supported by advocacy and accessed a solicitor for Tribunal hearings. Some had completed advance statements recording their views of how they wished to be treated, and everyone we saw had a named person who was involved in care planning.

Paperwork relating to treatment under Part 16 of the Mental Health Act was in good order, and the relevant consent to treatment certificate (T2) and certificate authorising treatment (T3) forms were present in the files reviewed. It is best practice to renew all such consent to treatment certificates after three years. However, in one individual case this had not happened. A T3 form had not been reviewed for four years and although the T3 was still valid we asked that the doctor request a Designated Medical Practitioner visit for the T3 to be reviewed. We did see in one case that a T2 form, included as required medication to be administered intra-muscularly for agitation. Our view is that a patient is very unlikely to be consenting to IM medication for agitation at the time this is felt to be urgently necessary, and this was discussed with the clinical area manager on the day.

Rights and restrictions

Many of the patients in Bruar ward had come into the mental health service through contact with criminal justice proceedings. The ward is locked in accordance with their locked door policy. All the patients on the ward at this time are detained. One patient in the unit had been made a specified person and documentation seen on our visit appeared to be in order.

Activity and occupation

There is a strong ethos of rehabilitation, supporting individuals to move from the locked ward environment into the community unit and on into independent living. We found good evidence of nursing staff and occupational therapists providing a range of inputs, including skills development and facilitating activities both on and off the units.

Each patient is encouraged to budget and cook for themselves, according to their skills level, with assistance provided if necessary. Those patients we spoke to who engaged in these activities were satisfied with the support offered and the progress they were making towards more independent living.

The physical environment

We looked round both units. No issues were raised regarding the physical environment. Nursing staff mentioned they had a continual struggle with infection control staff in order to be able to use the kitchens for rehabilitation purposes. Storage of food stuffs, for instance, had to comply with standards set for acute general hospital settings which are very different from the homely kitchen environment they were trying to encourage.

Summary of recommendations

No recommendations were made as a result of this visit.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Kate Fearnley

Executive Director (Engagement and Participation)

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 MWC 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

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk