mental welfare
commission for scotland

Mental Welfare Commission for Scotland

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

Date of visit: 8 March 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.

The patients, formerly of Morlich Ward, are currently located in Maree Ward whilst Morlich Ward is undergoing building work. Maree Ward is a 12-bedded, mixed-sex unit providing inpatient hospital care for older adults experiencing complex functional mental illness other than dementia and, at present, early stage dementia. The ward supports those patients whose care cannot be managed safely within community settings. The accommodation consists of single bedrooms and en-suite bathrooms. It is the inpatient facility for North Highland excluding Argyle and Bute.

On the day of our visit there were no vacant beds. The unit has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, and psychology staff. Referrals can be made to all other services as and when required.

We last visited this service during our themed visits of 2019 and the recommendations are published in the report on visits to older adult functional wards.

On the day of this visit we wanted to follow up on those recommendations and also hear how patients and staff have managed throughout the current pandemic. We also wanted to find out how the service is functioning during the decanting period whilst upgrading work is being carried out in Morlich Ward.

Who we met with

We met with and/or reviewed the care and treatment of eight patients and spoke with one relative by telephone.

We spoke with the senior charge nurse (SCN) and consultant psychiatrist on the day. No managers were available due to sickness and/or other absence.

Commission visitors

Douglas Seath, Nursing Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Nursing care plans

The patients we spoke with were generally positive about the care they received. One person told us that the staff appeared very busy at times, but were approachable and spent one-to-one time when they had the opportunity. On the visit, we found detailed person centred care plans, though not in all cases, and there was not always clear evidence of patient and family involvement in care plans, although the relatives were clearly meeting with staff as evidenced in the continuation notes. All files were in written format. The care plans followed on from detailed initial risk assessments which were reviewed regularly. The 'Getting to Know Me' forms were also informative and provided much personal detail about the individual's life. We saw, together with full medical histories, physical health care needs were being addressed and followed up appropriately.

When we reviewed the care plans we were unable to locate robust reviews which targeted nursing intervention and individuals' progress. We discussed this with the nurses on duty and the SCN. There was a clear awareness of reviews happening but not being reflected in the paperwork. We are aware that within the service as a whole that care plans and reviews are being worked on and suggested using the Commission guidance available on our website to help in the process. We recommend that an audit of the care plan reviews is carried out to ensure that they reflect the work being done with individuals towards their care goals and that the reviews are consistent across all care 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

Recommendation 1:

Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Multidisciplinary team (MDT)

The unit has a broad range of disciplines either based there or accessible to them. However, there is only limited input from occupational therapy (OT). The ward has regular input from pharmacy and physiotherapy is available by referral. It was clear from the very detailed MDT meeting notes that not everyone involved in an individual's care and treatment is able to attend the meetings and update on their views. With five consultant psychiatrists involved in providing input to the ward, there is a variation in approaches to patients and families attending the MDT. In general, patients' views are sought prior to the MDT meeting and the consultant meets with the patient post meeting to feedback on decisions made. Rating scales, both subjective and objective, are in use to assist with formulation plans and there was clear discharge planning information in the MDT meeting notes.

Use of mental health and incapacity legislation

Where patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (‘the Mental Health Act’), those we met with during our visit had a good understanding of their detained status. Where Powers of Attorney were in place under the Adults with Incapacity (Scotland) Act 2000 (‘the AWI Act’) the powers were generally recorded on file.

Part 16 (s235-248) 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. We found that two consent to treatment (T2/T3) forms were missing from prescriptions for patients detained under the Mental Health Act. These should be present with the prescriptions to ensure all medications are legally authorised. The forms were subsequently located elsewhere. There were two other anomalies found in prescriptions for voluntary patients and these were amended on the day. Covert medication had appropriate supporting documentation to authorise medications. Individuals who lacked capacity to consent to their medical care and treatment had s47 AWI Act certificates in place as required.

Recommendation 2:

Managers should identify a system of auditing consent to treatment forms in order to ensure any errors are immediately rectified so that treatment given is legally authorised.

Rights and restrictions

Maree Ward currently operates a locked door policy, commensurate with the level of risk identified within the patient group. The risk is mainly attributable to the fact that four patients with dementia have been admitted to the ward due to lack of beds elsewhere. Patient rooms are not locked on the ward unless individuals request this (to safeguard their belongings when they are out of their room).

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

We are aware that during the pandemic restrictions put in place had meant that various activities outwith the unit had to be put on hold but that some activities previously provided by the social centre were provided in the ward. However, we heard about the efforts of nursing staff to ensure there was always activity available on the unit for patients. We also heard that the photography and greenspace projects had commenced and that this had been greatly received.

Now that restrictions are beginning to lift and patients are once again able to resume community activities, we heard from staff that they are having to again adapt and cope with

the changes in routine this brings them. We noted that staff have gone the extra mile in spite of shortages to facilitate activity and ensure patients' needs in this area are met.

The physical environment

The layout of the ward consists of 12 single rooms. There is a lounge area and a dining area for the patients, both are bright and spacious. The environment was bright and airy and we were able to see where efforts have been made to manage within a ward not designed for its current usage.

The communal and sleeping areas were less personalised than would have been expected for the patients in this type of ward. However, we had a discussion with the SCN about the plans for the refurbishment of their own ward and she was very enthusiastic about the ideas they have and was keen to have us return to see it once completed.

Any other comments

Throughout the visit we saw kind and caring interactions between staff and patients. Staff spoken with knew the patient group well. It was good to note that patients we met with praised the staff highly.

During the pandemic restrictions, staff are clear that the drop in footfall in the unit benefitted the patients as they had less people to cope with in their living space. There have been no recent cases of Covid-19 on the unit. However, there have been cases in other parts of the hospital complex and this has created difficulties with new admissions and need for isolation.

Of the patients diagnosed with dementia on the ward, two are awaiting the outcome of welfare guardianship applications and one a care package being set up. The fourth person is still undergoing appropriate treatment.

Summary of recommendations

1. Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

2. Managers should identify a system of auditing consent to treatment forms in order to ensure any errors are immediately rectified so that treatment given is legally authorised.

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.

Suzanne McGuinness
Executive Director (Social Work)

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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