Mental Welfare Commission for Scotland

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

Date of visit: 27 May 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Morar Ward is a 24-bedded, adult mental health assessment and treatment ward. The ward had moved to a temporary setting within Maree Ward around nine months previously, to allow for health and safety work including anti-ligature measures to be completed. We were told that the aim was to move back to the newly refurbished Morar Ward in July 2025. Two beds in the ward were designated for individuals with problems relating to substance use. Due to clinical need, these were regularly occupied by people with acute mental health needs, however on the day of the visit two individuals were admitted for detoxification.

On the day of our visit, the ward was full although two individuals were discharged during the course of the day. This was an unannounced visit to Morar Ward.

We last visited this service in November 2023 on an announced basis and made recommendations on the audit of care plans, ensuring there was dedicated psychology input, that the provision of adult acute care beds, including the provision of alternatives to deal with crisis and home treatment, should be reviewed, that whiteboards in the duty room should ensure they protected confidential information and on the management of smoking.

An action plan was received from the service addressing all of the recommendations. During this visit, we wanted to meet with people receiving care and treatment on the ward, and check on the progress of the action plan.

Who we met with

We met with, and reviewed the care of four people, three of whom we met with in person and one who we reviewed the care records of. There were no family/carers visiting the ward on the day to speak with, but we asked the senior charge nurse (SCN) to tell any who visited later or over the days that followed that we would be happy to speak with them.

We spoke with the hospital manager, the SCN, the clinical director and various ward staff throughout the day of the visit.

Commission visitors

Audrey Graham, social work officer

Lesley Paterson, senior manager (practitioners)

What people told us and what we found

Care, treatment, support, and participation

The individuals that we spoke with reported many positives about interactions with staff and the care and support offered. One said, “the staff are brilliant”; another said, “they help in any way they can”. Individuals expressed views which related to wider factors such as “the care is first rate, but I don’t understand the system”.

We found that the ward, including the main staff office, was very busy and some feedback reflected this, with individuals telling us that they held back from asking for what they needed, “I’m a bit scared to ask for things, but I’ve always been that way” and “I don’t tend to vocalise what I need”. Another said, “If I’m all doom and gloom they leave me alone”. This feedback highlighted to the Commission staff the importance of ongoing orientation and support for individuals through the admission journey to Morar Ward, in helping them to understand the ward routine and boundaries. This was particularly important during a first admission and in an acute ward environment, where increased levels of clinical activity could lead to a lack of understanding of individuals’ subjective experiences of disorientation and powerlessness in such an environment.

On the day of the visit, we observed warm and caring responses towards individuals from staff through the course of the day. The use of humour by staff created a relaxed and warm atmosphere at times and we did not see any expressions of frustration by staff when the level of demand increased. It was good to hear from the SCN about their sense of pride in the team and their view overall of the staffs’ high level of commitment to and their compassion for individuals. It was also positive to hear from the SCN about the focus on supporting staff through the course of their shift in terms of planning/prioritising and well-being, through morning run-down meetings, mid-shift huddles and regular five-minute well-being checks.

Care records

We saw that ‘admission and discharge integrated care pathway’ documents were in place in each file reviewed. We found this to be a helpful document, offering a thorough guide for staff through the essential steps and tasks requiring completion through the individuals’ journeys.

Care records were held in paper files and the documentation that we reviewed related to individuals who had quite recently been admitted, the longest admission being five weeks. A fuller overview would have been possible had there been people who had been admitted on a longer-term basis.

The care plans that we reviewed were person-centred but did not appear to address the full range of individuals’ needs. Individuals did not seem to be aware of their care plans and did not appear to have copies, although there was evidence of individual

participation in multidisciplinary team (MDT) meetings where care plans were discussed. The Commission would advise that copies of care plans should be offered routinely and be in an accessible format to aid individuals' ownership and their understanding and focus on identified goals.

Recommendation 1:
Care plans should reflect the holistic needs of an individual and be agreed with maximum participation of the individual.

The risk assessments we reviewed were completed on admission, had associated risk management plans, with involvement of the MDT and were reviewed at MDT weekly meetings. It was positive to note that the staff team had used the STORM model for one individual who experienced suicidal ideation. STORM is a model which addresses self-harm, guides risk assessment and supports safety planning to aid risk assessment and risk management.

It was unclear from the care records that we reviewed whether care plan goals were updated following MDT review, although we were reassured by the SCN that this was the case and that there was a focus on keeping individual care plans dynamic at the regular 'pathway meetings'. These involved a range of professionals, including social work, occupational therapy and physiotherapy.

We were informed by the SCN that a monthly record keeping audit programme was in place. This was stored digitally and an action plan created following each audit. We found that care records included information on individuals' personal and social histories in different formats, including documentation on the Care Programming Approach (CPA), a multidisciplinary assessment and care management approach for people with complex mental health needs; this was held in their files and in the summaries completed by resident doctors.

Recommendation 2:
Auditing of care plans should be evidenced in care records.

The Commission visitors were of the view that person-centred practice could be enhanced if a document, such as the 'Getting to Know Me' template or similar, which offers a quick picture of what is important to the individual, was adopted as standard.

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.

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

Multidisciplinary team (MDT)
The team in Morar Ward was mostly made up of registered mental health nurses (RMNs), with input from consultant psychiatrists, occupational therapy and physiotherapy staff. Allied health professionals (AHPs) input into care and treatment is provided on a referral basis and there were no concerns noted about their capacity to respond.

We were told by the clinical director and SCN that an adverse event review in a related clinical area (intensive psychiatric care unit) had recommended that there should be enhanced provision of evidence-based psychology input for in-patients. This finding is also applicable to Morar/Maree Ward. We note that this was also a recommendation from the last two Commission visits. We were told that provision had improved but that currently the ward only had two sessions of psychology time per week.

Recommendation 3:
Hospital managers should ensure that there is sufficient dedicated clinical psychology input to the ward to support the development of psychological therapies and interventions across the ward.

The SCN described considerable benefit from the input of the psychologist in terms of assessment and formulation of individuals. It was positive to note that many of the nursing staff have been trained in DECIDER skills, a cognitive behavioural approach aimed at enabling people to develop skills to manage the impact of emotional distress. We were also encouraged to hear that a report evidencing the case for increased clinical psychology provision had recently been submitted to senior managers but were concerned to hear that this gap had been an issue for more than two years.

Individuals told us about being involved in their MDT review meetings each week. One person said that he enjoyed going along to these and felt listened to.

There was also evidence of family/carer attendance at MDT meetings. Overall, the recording of MDT weekly reviews was good. It was noted that accountability for actions agreed could be enhanced by recording the full names of all present and including a column specifying who was responsible and by when. This was fed back to the SCN on the day of the visit, and we asked for this to be actioned.

It was positive to see the recording of individuals' views, in their own words, in the record.

As was the case at the previous visit, community mental health teams (CMHT) continued to keep in contact with individuals who were known to them and who had been admitted to the ward; the SCN attended weekly meetings with the CMHT. This

was positive in terms of ensuring the continuity of care and for robust discharge planning.

However, as on our previous visits, there were concerns about the absence of any crisis or intensive home treatment team (IHTT). There was a commitment following a previous Commission recommendation to consider the viability of extending CMHT cover to seven days, but we were told that this had not progressed. We heard that the establishment of a step up/step down resource, which could be accessed to facilitate early discharge and prevention of admission, where people could be supported for up to 30 hours per week in self-contained accommodation, had been a positive development.

We also heard from the hospital manager and the SCN about ongoing work to re-configure the whole New Craigs site to respond to the evidence and need for more adult acute beds. We look forward to hearing more about this on future visits to the hospital.

Use of mental health and incapacity legislation

On the day of the visit, 13 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained people, who are either capable or incapable of consenting to specific treatments.

At the previous visit in November 2023, consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place and corresponded to the medication being prescribed.

Unfortunately, on the day of this visit, we found that the central file which should have been used to store this paperwork was not properly in use; it contained only two out of the nine T2/T3 certificates which were required. We were concerned that there did not seem to be a clear system for tracking and updating these certificates either.

There were several examples of medication being prescribed which was not authorised. We looked at medications prescribed for informal individuals, and we found that four of the eight were prescribed as required intramuscular sedative medication. The Commission has concerns about intramuscular ‘as required’ medication being prescribed for people who are informal. This is because it is likely that they would not consent to receive the treatment if it was later administered at a time when they were distressed. We consider it best practice for a medical review to be arranged if circumstances arise where intramuscular as required medication may be required.

These issues were discussed with the hospital manager, SCN and the two consultant psychiatrists for the ward on the day of the visit. We consider it to be the joint

responsibility of RMOs and the nursing team to ensure the prescribing and administration of medication is carried out with proper authority in place. We were told that there was generally a high proportion of people detained in the ward and that there were challenges in keeping up with notifications and updates required as they currently did not have a ward administrator. We advised that simple measures, such as including a prompt relating to certificate expiry dates in the MDT template that could then be checked at the weekly meetings, would help. We suggested that discussions take place with the central Mental Health Act administrator at the hospital for increased support.

Recommendation 4:
Hospital managers must ensure that all psychotropic medication given under the Mental Health Act is legally authorised and that a system for tracking, updating and storing paperwork relating to authority to treat under Part 16 of the Mental Health Act is put in place.

There were some individuals in the ward who had measures in place under the Adults with Incapacity (Scotland) Act 2000 and these were indicated on the whiteboard in the main office as 'AWI'. Staff did not seem to be clear whether this referred to a section 47 certificate, a guardianship order or Power of Attorney (PoA). We advised that recording of the specific measure that was in place, on the whiteboard, would ensure that staff could see this at a glance; for example, where there was a formal proxy decision maker in place who must be consulted with relating to individual care and treatment.

Rights and restrictions

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 found that one individual had an advance statement on file which was ten years old, and we asked that support was offered to update this and that staff remain mindful of encouraging individuals to consider making advance statements.

The individuals we spoke to did not have or wish advocacy support and we did not see any posters in the ward promoting advocacy. However, it was good to hear about the local advocacy organisation and some of their activities in the hospital as a whole, including a project to explore people's views on the policy relating to locking ward doors.

The hospital manager advised us that there was support amongst the individuals in the hospital for the doors to be locked to increase their sense of safety and security.

It was commendable that advocacy was employed to gather people's views on this issue to inform hospital-wide policy.

We spoke to two individuals who were informal and explored their understanding of leaving and entering the ward. It was apparent that neither felt restricted in this regard. We spoke to one person who was detained who, while reporting that they were not clear on their rights, did express confidence that their psychiatrist knew them well and would allow more time out when they were more settled.

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 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. Where specified person restrictions were in place under the Mental Health Act, we found that there was a reasoned opinion in place. One certificate had errors which were rectified on the day.

Activity and occupation

We heard from individuals that they enjoyed the opportunity to play pool, table tennis and badminton and to draw and paint in the activity room in the ward.

None of those that we met with raised concern about being bored although we did hear that the ward activity co-ordinator had unfortunately been on long term leave. The hospital had a large hall which served as a 'social centre' for all of the wards and at our last visit there was concern raised that this should be open longer.

It was good to hear that this had been addressed and that two Band 3 staff were now in post to run the centre, along with the manager and existing Band 4 member of staff. We heard that the hospital health and well-being team operated from the centre. A local arts organisation had been in to do an art project and there were more groups running from the centre, such as on digital inclusion and smoking cessation. There was a timetable in all the wards.

It was interesting to hear that there were plans in place to work with the University of the Highlands and Islands to explore how the hospital grounds could be used to benefit individuals more, about the setting up of a 'Friends of New Craigs' charity and of considerations for setting up the hospital café as a social enterprise to provide supported employment opportunities.

The physical environment

As noted, on the day of the visit, Morar Ward was temporarily located in what had been Maree Ward, while ligature risk reduction work and other refurbishment was being undertaken. The move had taken place approximately nine months previously and we heard that it was hoped the move back to the newly upgraded ward would

take place in July 2025. We found that the ward layout was not easy to navigate, and that nursing staff were only able to observe a limited area from the main office. This seemed to add to some uncertainty through the course of the day about whether the two people who were scheduled for discharge had gone, whether rooms had been cleaned and where other people were, with staff asking frequent questions of other staff about these details.

It may be that a more detailed handover or an additional staff huddle was needed to compensate for the poorly designed layout and to support communication. We noted that there were a number of corners to turn, obscuring a clear view for staff. Unfortunately, we heard that the ward being refurbished was the same layout, but that this design flaw was being mitigated by the installation of mirrors.

The ward garden was a courtyard space and did not contain much greenery. It was not a therapeutic or pleasant space for individuals to sit in. There was a large ashtray in the garden space and also signs to advise individuals not to smoke, representing mixed messaging. We did not observe any smell of smoke wafting back into the communal space from the garden and there was reassurance given that nicotine replacement therapy and smoking cessation groups were available.

We found the temporary ward environment to be clinical and sparse, and we would advise that if the move back to Morar ward was delayed beyond July, that hospital managers should consider allocating resources to improve the ward and garden areas in small ways, with the aim of making them more homely and comfortable.

We hope that the move back to the newly refurbished ward goes well and brings benefit to individuals and staff and we look forward to visiting next year.

Summary of recommendations

Recommendation 1:
Care plans should reflect the holistic needs of an individual and be agreed with maximum participation of the individual.

Recommendation 2:
Auditing of care plans should be evidenced in care records.

Recommendation 3:
Hospital managers should ensure that there is sufficient dedicated clinical psychology input to the ward to support the development of psychological therapies and interventions across the ward.

Recommendation 4:
Hospital managers must ensure that all psychotropic medication given under the Mental Health Act is legally authorised and that a system for tracking, updating and storing paperwork relating to authority to treat under Part 16 of the Mental Health Act is put in place.

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 an individual's care, treatment, and support are 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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