Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 14 October 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

Ruthven Ward is a 24-bedded, mixed-sex dementia assessment and complex care ward which was fully occupied on the day of our visit. Of the 24 individuals admitted, 11 of these were individuals who were receiving health board complex clinical care (HBCCC). Those admitted to Ruthven Ward were either acutely unwell or in crisis as a result of their cognitive impairment and cannot be sufficiently supported by the most intensive support services available in the community.

We last visited this service in July 2023 on an announced basis and made recommendations on improvement of risk assessments and care plans, involvement of family/carers, recording of multi-disciplinary team (MDT) review meetings and the provision of meaningful activity. An action plan was received from the service detailing what would be done to address each issue.

On the day of this visit, we wanted to follow up on the previous recommendations and to look at improvements in the areas of care planning, multidisciplinary meetings and provision of meaningful activities which had also been the focus of a recommendation following a previous visit.

Who we met with

We met with, and reviewed the care of six people, who we met with in person and reviewed the care notes of. Some of these individual meetings were very brief due to the level of cognitive impairment and/or distress that the person experienced. We also met with three relatives.

We spoke with the service manager for older adults, the senior charge nurse, the nurse team lead and the associate nurse director (interim). We met with a Band 5 staff nurse and a healthcare support worker.

Commission visitors

Audrey Graham, social work officer

Margo Fyfe, senior manager

What people told us and what we found

Care, treatment, support, and participation

The majority of individuals being cared for in the ward had a significant degree of cognitive impairment and were not able to have detailed discussions about their care and treatment. We had short conversations with some, observed them on the ward and in their interactions with staff. Staff appeared to know individuals well and were attuned to their needs. The staff that we spoke with were able to clarify for Commission visitors what individuals meant at points when this was difficult to understand.

We observed considerate, warm and kind interactions between staff and individuals. One relative commented positively that in every visit they had made to the ward across a four-year period, they received smiles and a warm welcome from staff. In relation to the standard of care delivered, one family member told us, “I have no words to describe it: it’s first class”. Another said, “I don’t think my husband would be better cared for anywhere else”.

Family members referred to the atmosphere in the ward as “lovely” and “friendly” and talked of staff’s awareness of the emotional impact on them; “they always check in on me”. One family member did say that at points, communication from the ward could be better, particularly when something changed. This seemed to them to be linked to assumptions made by nursing staff that families and carers knew more about how things worked on the ward than they actually did; as this was their relative’s first admission and the decline in mental state had been rapid, they told us “I don’t know how this all works”. There was a sense from relatives that staff were approachable, including at ward management level where “the door is always open”.

In reviewing care plan documentation, we observed care plans relating to physical health to be more prominent and clearer than care plans relating to mental health. There were gaps where some people did not have a care plan relating to mental health at all, or there was a lack of detail in terms of stress and distress formulations and this not being linked to care plans. A ‘daily care plan’ document was completed for individuals, which staff use to confirm that tasks relating to aspects of care, such as personal care, physical health, nutrition and fluid monitoring, are complete. We were unsure if this was a useful approach and struggled to see how it linked to the wider care plan or fed into MDT reviews. We suggested that it may be worthwhile for managers to undertake a review of the usefulness of this tool.

Overall, there was a good level of detail in the continuation notes. The records that we reviewed included a focus on the content of the psychotic experiences of individuals and on the detail around behaviours that challenge, providing a good source to draw information on for reviews of care and treatment. Reviews were in place but were not recorded in any detail. We did not see how interventions changed as a result of reviews, which would have enabled progress against identified goals to be achieved. The section in the care plan documentation prompting staff to consider the individual's strengths, the 'personal toolkit' was generally not complete. We consider that taking time to reflect on the individuals' own resources through the care planning process is important.

Recommendation 1:
Managers should ensure that nursing care plans are person-centred and holistic, with a clear focus on mental health and well-being and that they evidence participation of the individual and/or carer in the care planning process.

Recommendation 2:
Reviews of care plans should be regular, fully reflect the individual's progress towards stated goals and inform the update of necessary interventions to achieve the person's goals. There should be a system of manager audit to ensure this is being achieved.

Risk assessments and risk management plans were evident in the care records but some had not been reviewed for a considerable period of time. In one record, a brief overall risk assessment had been completed but no risk management plans could be located.

It was noted in discussion with ward managers that for some time, there had been a gap in terms of psychology provision. A new psychologist had started that week for one day a week and the focus will be to support staff with formulations and stress and distress care planning. We look forward to seeing the impact of this at our next visit.

It was good to see family/carer involvement in the completion of 'Getting to Know Me' documents. This tool has the potential to provide a holistic and person-centred understanding for staff about the uniqueness of the individuals for whom they are caring. It was evident from listening to family/carers and in observing interactions between staff and individuals' that a person-centred approach to care was being taken. However, this was not evident in the care planning and review documentation overall. Use of a model such as 'The Triangle of Care', to aid a therapeutic partnership approach between individuals, unpaid carers and professionals, could be helpful in care planning. It was good to hear of plans to start a carer support group and the carers we spoke with said this would be of interest to them.

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.

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

Multidisciplinary team (MDT)
We heard that there was a good level of cover in the ward in terms of input from four consultant psychiatrists. We were informed that they tended to be on the ward one day a week, so this could slow decision making to the next week, however there was a plan to pilot a daily 'rapid rundown' involving the junior medical staff to address this.

It was good to see input through individual records from physiotherapy, podiatry and from spiritual care. We saw little evidence of occupational therapy (OT) involvement in the records reviewed and discussions with staff indicated that the OT service across the hospital site is significantly stretched. This is of concern considering the extent to which cognitive issues affect functioning in this group of individuals.

Recommendation 3:
Managers should review OT input to the ward to ensure individuals are receiving the full care they require.

We were interested to hear about a relatively new 'Discharge Planning App' being used, which linked together relevant health and social care professionals across hospital and community in progressing discharge plans. Staff were enthusiastic about the positive impact that this was having in terms of communication, accountability and in addressing delays; we felt that this was a very positive development.

We saw evidence that MDT reviews were taking place regularly. However, of the records reviewed, most were attended only by medical and nursing staff. After our last visit, there had been an undertaking by ward managers to ensure that fuller MDT reviews took place at set intervals for individuals; reviews were planned to take place within a week of admission, after one month, at three months and when there was a plan for discharge. We did not see any indication in records that this had been happening and the SCN confirmed that it had not. There was a need for improved recording of meetings to ensure accountability including full details of those in attendance, clear documenting of agreed actions, responsibility for actions and timescales.

Recommendation 4:
Managers should ensure that MDT reviews draw on the expertise of the wider group of involved professionals and family/carers at specific intervals and that meetings are recorded fully to ensure accountability for actions agreed.

We saw limited evidence of the involvement of family/carers in MDT reviews and the family/carers we spoke to had only attended one or two meetings or felt they had to ask to be included. While the family/carers we spoke to did feel listened to and involved overall more action around involving them more formally in reviews seemed to be required. This would ensure that their knowledge and observations of their loved ones’ progress was fed in effectively to the evolving care plan.

Use of mental health and incapacity legislation

On the day of the visit, 15 people out of 24 were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Paperwork relating to detention was in order and in evidence in the care records.

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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed relating to 14 out of the 15 individuals who were detained. One T3 required to be re-done to include an additional medication being prescribed and this was raised with the SCN on the day. There were no consent to treatment certificates (T2s) in place as all detained individuals required a T3 certificate. For individuals who had covert medication in place, all appropriate documentation was in order.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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 and record this on the form. Section 47 certificates were in place for all 24 individuals, and overall, these were in good order. All but three out of the 24 certificates we reviewed had treatment plans in place. In 10 of the certificates we reviewed, it was unclear whether there had been discussion about the treatment plan with the relevant power of attorney or guardian and this was raised with the SCN on the day who agreed to take this to medical staff.

Rights and restrictions

Due to the complex needs of the patient group in Ruthven Ward, a locked door policy was in place. We were satisfied that this was proportionate in relation to the needs of the patient group and no one we met with raised any concerns about access to/egress from the ward.

Of the detained individuals we met with, two were able to express a clear awareness about their rights under the Mental Health Act. One individual was positive about advocacy support saying,” she speaks up for me”. It was good to note that one individual had an advance statement, and this was accessible in their care records. 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.

For one individual whose care record was reviewed it appeared that early in their admission, the criteria in terms of detention under the Mental Health Act may have been met but was not applied. While there was evidence of this being discussed between medical and nursing staff, it appeared there had been no consultation with the mental health officer (MHO) service, which may have offered an alternative perspective and clarity; the individual had since settled and was accepting of care and treatment. The RMO was absent from work at the time of the visit but we will contact them for further discussion on their return and the issue was raised with the SCN.

Activity and occupation

Through the course of the visit, we observed staff interacting and in conversation with individuals one a one-to-one basis or in small groups, who were completing colouring and crafts. The interactions we observed were warm and humorous and there was a pleasant, calm atmosphere in the ward.

It was noted that providing activities was the responsibility of the nursing staff and that there were no dedicated activities staff, as had been the case at our previous visit. When the level of clinical activity was high this impacted on the ability of staff to offer one-to-one sessions and group activities. It was good to hear that there was some opportunity for individuals to take part in groups and trips organised by the social centre, which services the whole hospital site.

We heard that staff feel the need to supplement the arts/crafts materials available by bringing in additional materials which they have paid for. We did not think that this should be necessary or expected, and we would ask that hospital managers review the availability of funds to provide sufficient materials.

It was clear from discussion with the SCN, that she and the staff prioritised the importance of providing meaningful and person-centred activities as much as they could, but that there was a significant gap in terms of staff resource to do this. It was good to hear that there had been a recent major recruitment exercise for Band 3 staff and that the SCN was advocating that two out of four of these new staff should focus on activity provision. We would strongly support this proposed plan to address the current gap.

Recommendation 5:
Managers should prioritise appointing dedicated activities staff for the ward from the recent group of new recruits.

The physical environment

The ward environment had recently undergone significant refurbishment. We found the space to be bright, colourful and welcoming. Staff had been thoughtful about the lighting around the ward and had liaised with the contractor to have settings modified to ensure it was not too bright and could be adjusted in the evening and through the night. Communal areas were pleasant and clean and there were smaller quieter spaces available for people. There was accessible and well maintained outside space and plans to enhance this.

It was noted that one individual did smoke in the garden area and that there was a belief that due to their complex needs, there was an option to make an exception. We advised that no exceptions could be made in this regard and that the ward should adhere to the prohibition of smoking outside hospital buildings regulations made in 2022.

Summary of recommendations

Recommendation 1:
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Recommendation 2:
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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 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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