Mental Welfare Commission for Scotland

Report on unannounced visit to:
New Craigs, Affric Ward, Leachkin Road, Inverness, IV38 8NP

Date of visit: 20 May 2026

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

Located in the main building of New Craigs Hospital, Affric Ward (currently decanted to Maree Ward) is a 10-bedded intensive psychiatric care unit (IPCU).

Affric Ward provides intensive treatment and interventions for individuals who are experiencing severe mental health symptoms and who present with an increased level of clinical risk that requires a higher level of observation, treatment and support which cannot be safely delivered in a general psychiatric ward.

IPCUs generally have higher staffing levels, with staff possessing specialist skills and experience in caring for acutely unwell individuals. Individuals may be admitted following referral from a general adult psychiatrist, or transferred from prison due to mental ill health, or admitted through the courts in relation to offending behaviour associated with mental disorder.

On the day of our visit, there were 10 males on the ward and no vacant beds.

We last visited this service in June 2024 on an unannounced visit and made recommendations regarding occupational therapy provision, access to psychological therapies, the management of paper-based care records, restrictive practices and the condition of garden furniture. The service subsequently advised that actions had been taken to improve these areas.

During this visit, we wanted to follow up on the previous recommendations, to meet with individuals, relatives/carers and staff to hear their views and experiences of the care and treatment being provided on the ward.

Who we met with

Although this visit was unannounced, we were still able to meet with six individuals and review their care.

Following the visit, we discussed the care and treatment of three individuals with their relatives by telephone.

On the day of the visit, we met with the hospital manager, the senior charge nurse, the nurse director, the clinical lead and the consultant psychiatrist. We also spoke with registered nurses, healthcare support workers and student nurses.

Commission visitors

Karen Beattie nursing officer

Mark Richards nursing officer

What people told us and what we found

The individuals we met with discussed a range of issues relating to their care and treatment in the unit; they were generally positive about their experience in Affric Ward.

Throughout the visit, we observed warm and respectful interactions between staff and those in the ward.

Individuals spoke positively about staff and the support they received. Comments included, “staff are brand new” and “I feel I am in a much better place.” One individual described how unwell they had been when first admitted and stated that they were now “getting on track”.

Some of the feedback we received reflected people’s frustration with restrictions relating to smoking.

Individuals described their psychiatrist and the wider ward team as approachable and easy to talk to. The value of the multidisciplinary team (MDT) meeting was also highlighted, with those that we spoke to describing how supported they felt when participating in the decisions about their care and treatment.

Individuals told us they were treated with dignity and respect and that staff respected their privacy by knocking before entering their rooms.

Awareness of named nurses varied, however people generally reported feeling comfortable approaching any member of staff for support. One person described the staff as “magic” and spoke about the importance of receiving care from staff who knew him well.

In relation to meaningful activity, all individuals spoke positively about the role of the activity coordinator and considered this support particularly important while access to the hospital grounds was restricted. Those that we spoke with were content with their accommodation. They reported that their rooms were comfortable, temperatures were appropriate, and that staff were readily available if assistance was required.

The temporary decant to Maree Ward, which is smaller than Affric Ward, has resulted in more limited space. A small corridor area had been adapted to provide a quiet space and activity area and includes a treadmill and a table for board games and other activities. While space was limited, none of the individuals we met expressed concerns about the temporary accommodation or identified any adverse impact arising from the move.

There were no relatives visiting during our time on the ward. However, following on from our visit, we took the opportunity to contact three relatives by telephone to

discuss their views of the care and treatment provided. All relatives spoke very positively about the staff team, with particular praise given to healthcare support workers. One relative commented that staff “give 120%”. Another relative acknowledged the challenges of working in an IPCU environment and expressed their appreciation for the resilience and commitment shown by staff.

Communication with families was described as generally good, although there were occasional examples of messages not being passed on. Relatives reported positive involvement in their family member’s care and stated that they were kept informed when incidents occurred. Physical healthcare needs were reported to be well managed, with praise given for support provided to ensure attendance at appointments such as scans and other investigations. One relative described the smoking policy as “challenging” for some patients.

We spoke with a range of staff on duty during the visit. Staff told us that the current ward environment was challenging due to its smaller size and the temporary loss of facilities that ordinarily were available in Affric Ward. However, staff were positive about the planned return to Affric Ward in June.

All staff expressed frustration regarding the current patient mix in the ward. They advised that five patients were appropriately placed in the IPCU setting, while the remaining five would be more suitably cared for in a general adult psychiatry ward. Staff considered that some individuals were experiencing restrictions associated with an IPCU environment that were no longer proportionate to their clinical needs. We were informed that five people currently had unescorted leave from the ward and that one person had been awaiting transfer to a general adult psychiatry ward since January.

Staff also reported limited access to clinical supervision and appraisal processes. They advised that staff meetings had only recently recommenced. Concerns were expressed regarding the admission and ongoing management of an individual whose needs staff felt could not always be safely or appropriately met in the ward environment. We raised this with senior managers who identified that an incident review had been undertaken and recently concluded; the learning had been shared with staff.

All staff commented on the cohesiveness of the team and the ongoing support from colleagues, however a number raised concerns over inconsistent clinical decisions that occurred at times and feeling that senior managers could be more visible in the ward.

Care, treatment, support, and participation

Care records are currently maintained in paper format. We reviewed six sets of care notes and found that a range of care plans were in place for everyone.

The quality of care plans varied. In some cases, it was difficult to identify how individuals had been involved in the development or agreement of their care plans. Some language used in plans suggested interventions were being delivered “to” the person rather than “with” the person. However, we acknowledge that individuals in an IPCU setting may, at times, be too acutely unwell to participate fully in initial care planning discussions. It is therefore important that care plans are reviewed and updated as individuals’ presentation improves, with increasing opportunities for meaningful participation over time.

We found that care plan reviews often lacked detail regarding progress against identified goals. In many instances, outcomes were recorded simply as “no change”, with limited narrative describing the effectiveness or impact of interventions.

Individuals we spoke with had only a limited awareness of their care plans. No individuals we spoke with had been provided with a copy; most described their understanding of care and treatment as being primarily informed through attendance at multidisciplinary team (MDT) meetings. The Commission would expect that care plans are routinely offered to individuals in an accessible format to support ownership and understanding of agreed goals.

Recommendation 1:
Care plans should clearly reflect assessed needs. Individuals’ participation in care planning should be consistently recorded, and they should be routinely offered a copy of their care plan in an accessible format.

Risk assessments were in place for all individuals and were recorded using a RAG-rated system, with interventions aligned to escalation in behaviours and levels of patient stress and distress. While the risk assessments had been reviewed, we found limited evidence of recorded changes, evaluation of effectiveness, or clear documentation of the frequency and impact of interventions.

This was discussed at feedback with senior managers, who acknowledged that reviews could be strengthened to include clearer recording of outcomes and any additional actions required.

Recommendation 2:
Reviews of both care plans and risk assessments should include clear detail regarding interventions, progress towards goals, and outcomes achieved. These should be subject to regular audit.

Care records
Care records are currently maintained in paper format. We were advised by senior managers that the implementation of an electronic care record system is being planned, however no definitive timescale was currently available.

During our previous visit, we made a recommendation regarding paper-based records, which were found to be bulky, disorganised, and at risk of loose pages becoming detached from the main file. On this visit, we found that files had improved in terms of organisation and overall robustness.

We found that not all of the documentation relating to an individual's episode of care was consistently held in the main record. For example, consent and authority-to-treat documentation had to be requested from medical records on the day of the visit. Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) documentation relating to welfare guardianship arrangements was not available on the ward. This meant staff did not have immediate access to key legal information required to confirm what powers were in place or to effectively monitor documentation, including expiry dates.

Recommendation 3:
All paperwork relevant to an individual's episode of care should be stored in the individual's care record and be readily accessible to staff on the ward.

Daily progress notes were generally well maintained. They were consistently dated, signed and detailed, and provided a clear overview of current progress. Records demonstrated evidence of one-to-one interventions and reflected regular communication with patients.

We also saw evidence of appropriate physical healthcare interventions and timely staff responses to periods of increased clinical acuity.

Overall, staff demonstrated a good knowledge of the individuals in their care. We also noted input from medical and occupational therapy staff, as well as regular documentation of communication with families to provide updates.

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.

Multidisciplinary team (MDT)
The multidisciplinary team (MDT) meeting was held weekly. Attendees included psychiatrists, registered mental health nurses (RMNs) and social work staff. Other professionals, such as community psychiatric nurses, were invited as required. Individuals and their named person or family members also attended where appropriate. Attendance by psychology staff was limited due to time constraints.

The MDT meetings were well recorded and reflected discussion and decision-making involving the individual, including onward referrals and agreed actions.

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

There is no dedicated clinical psychology service for IPCU. A previous recommendation was made regarding psychology input. There is now a whole-time equivalent (WTE) psychology resource covering all acute areas although this was reported as insufficient to meet the needs of the current patient population.

Recommendation 4:
Managers should review the provision of psychological therapies for individuals in the IPCU to ensure access to appropriate levels of psychological assessment and intervention in line with clinical need.

Similarly, a previous recommendation was made regarding occupational therapy (OT) input. We were advised that referrals to OT can be made for individual assessment when required, however overall provision remains limited. There is no routine occupational therapy representation at MDT meetings. Staff reported that this limits the ability to deliver a fully holistic approach to recovery, as individuals do not have consistent access to OT input.

Recommendation 5:
Managers should review occupational therapy provision in Affric Ward to ensure equitable access across the hospital and to support a more integrated assessment of individuals' functioning and recovery needs.

Staff also described challenges associated with the current group of people in the ward. At the time of the visit, only five individuals were considered appropriate for an IPCU setting. The mixed profile and needs of the current group was described as creating tension in meeting the principles of least restrictive care under the Mental Health Act. Individuals are unable to transfer to general adult psychiatry wards due to wider patient flow pressures and rehabilitation capacity. Staff reported that this has made it more difficult to deliver care in what should be a specialist IPCU environment and contributed to a perception that the ward lacks a clear specialist identity.

These concerns were discussed with senior managers, who acknowledged the current pressures. They advised that actions were being taken to address patient flow issues, including proposed bed reconfiguration across the site. This includes plans to increase adult acute beds, general adult beds, and older adult provision, particularly in relation to continuing care pathways. However, no definitive timescales were available, as implementation for the reconfiguration is dependent on capital funding.

Use of mental health and incapacity legislation

On the day of our visit, all 10 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Documentation relating to each person's detention was held in a dedicated section of the care records.

The individuals we met with demonstrated a good understanding of their detention status under the Mental Health Act. They reported receiving written information about their rights. We also saw evidence in the care records of legal representation and advocacy involvement to support individuals in understanding their legal status and exercising their rights.

Where individuals had nominated a named person, appropriate documentation was in place and involvement in care was evident. Relatives we spoke with were aware of their responsibilities in this role.

Part 16 (sections 235–248) of the Mental Health Act sets out the legal framework under which treatment may be given to detained individuals who are capable or incapable of consenting to specific treatments. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments, and the requirement for appropriate authorisation where medication is prescribed beyond two months in circumstances where an individual does not consent or is incapable of consenting. Treatment must be authorised by a T2 certificate (where the individual is consenting) or a T3 certificate (where the individual is not consenting or is incapable of consenting).

However, the T2 and T3 certificates were not available on the ward and had to be requested from medical records. We identified that one T3 certificate was more than two months out of date, meaning medication was being administered without valid legal authority. We also identified one T2 certificate where the prescribed medication did not match the consent recorded on the form. The Responsible Medical Officer (RMO) and Senior Charge Nurse (SCN) were alerted at the time of the visit.

There was no formal audit system in place to monitor compliance with statutory documentation. While reminders were being issued to RMOs via medical records, these were not consistently actioned.

Recommendation 6:
Hospital managers must ensure that all psychotropic medication administered under the Mental Health (Care and Treatment) (Scotland) Act 2003 is supported by valid legal authority. A robust system must be implemented to track, update and store all documentation relating to authority to treat under Part 16 of the Act.

Medication was recorded on the electronic prescribing system Hospital Electronic Prescribing and Medicines Administration (HEPMA).

Following the visit, we were informed by the hospital manager that T2 and T3 documentation had been reviewed and that a second opinion application had been submitted. An audit system is to be implemented to reduce the risk of recurrence.

Where an individual lacks capacity in relation to medical treatment decisions, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) must be completed by a doctor. This certificate provides legal authority for treatment and confirms compliance with the principles of the Act. The doctor is also required to consult with any appointed legal proxy decision-maker recorded on the form. We found that AWI Act documentation, including welfare guardianship paperwork, was not available in the ward records. This meant that staff were not aware of what was detailed in the powers.

Rights and restrictions

Maree Ward, where Affric Ward has been temporarily decanted to, operates a locked door arrangement commensurate with the level of risk identified for this group of individuals.

We discussed rights and restrictions with those that we met with. Most demonstrated a good understanding of their rights and their ability to access independent advocacy services, which were available on request. Individuals who had used advocacy services provided positive feedback regarding their experience.

The term “advance statement” refers to a written statement made under sections 275 and 276 of the Mental Health Act. These statements are completed when an individual has capacity to express their preferences regarding the treatment they wish or do not wish to receive. Health boards have a responsibility to promote awareness and use of advance statements. We identified one advance statement in the records reviewed, although we were informed that advance statements had been discussed with some individuals.

Sections 281–286 of the Mental Health Act provide a framework for the application of additional restrictions for detained patients, including designation as a “specified person”. Where such restrictions are applied, the principle of least restrictive practice must be observed. One individual in the ward was recorded as a specified person at the time of the visit.

A previous recommendation relating to blanket restrictions on mobile phone use has been addressed and this has now been replaced with an individualised, risk-based approach.

We have concerns that due to ongoing challenges with patient flow, several individuals are currently being cared for in an environment that does not represent the least restrictive setting appropriate to their needs. While staff are managing

these pressures as effectively as possible, the current IPCU remit is not appropriate for all individuals who remain on the ward, and this may have a potential impact on recovery.

Recommendation: 7
Managers must undertake a comprehensive review of patient flow to and from the Intensive Psychiatric Care Unit (IPCU), with particular attention to delays in transfer to rehabilitation and general adult psychiatric settings. This review should identify and address systemic barriers to timely discharge or step-down, including bed availability, access to rehabilitation services, and inter-ward transfer processes. Clear actions should be developed to ensure that individuals are cared for in the least restrictive and most appropriate setting in line with their clinical needs, and that IPCU capacity is used appropriately for patients requiring that level of specialist care.

There were no individuals on continuous interventions at the time of the visit.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

The range of activities currently available is limited due to the reduced space in the temporary ward environment. Affric Ward has more appropriate accommodation and facilities for activity provision.

Activity opportunities for individuals have been restricted as a result of the decant situation. A healthcare support worker provides 0.6 WTE dedicated time to support meaningful activity. We were advised that this input is largely dynamic rather than structured, with daily activity influenced by factors such as each individual's preference and mood, staffing levels, weather, and planned events.

Access to the gym was limited, with a treadmill available in a small, designated ward area. Some individuals attended the social centre; an activity resource located in the hospital grounds.

We were informed that the activity coordinator role is receiving supervision from occupational therapy, which is supporting the development of a more structured and goal-oriented approach to activity provision.

The physical environment

Affric Ward has been decanted to Maree Ward for two months while important ligature reduction work is being carried out to improve patient safety.

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

The environment itself is smaller than Affric Ward and it is austere and sparse although functional, with a lack of private rooms for staff and patients.

All bedrooms were a good size and had ensuite provision

Some damage was noted to one individual's bedroom wall; we were told that estates are responsive to any requests and that the damage had been reported.

The dining area had two tables and could not provide for 10 seats, however we were told that that most people will either eat in the dayroom or their own rooms.

We were informed that one individual requires intermittent seclusion, which is currently undertaken in their bedroom. This is not an appropriate environment for seclusion in terms of visibility and safety. We were also advised that the bedroom door had recently been damaged, with ligature reduction features designed to collapse under pressure. Staff reported that the orientation of the individual's room in Affric Ward previously allowed for improved observation due to mirror placement but currently it is very difficult to effectively observe them and this heightens risk.

This was discussed with senior management who told us the creation of an appropriate seclusion room had not been included in the current works to improve Affric Ward as there was additional funding requirements; they were considering the need for separate extension to Affric Ward to provide a safe seclusion space.

The move back to Affric Ward is planned for June and while the current accommodation has served as a temporary measure it is not appropriate for longer term provision.

The previous recommendations including replace of garden furniture in Affric Ward; we were told this is part of the current upgrades taking place in the ward.

Summary of recommendations

Recommendation 1:
Care plans should clearly reflect assessed needs. Individuals' participation in care planning should be consistently recorded, and they should be routinely offered a copy of their care plan in an accessible format

Recommendation 2:
Reviews of both care plans and risk assessments should include clear detail on interventions, progress towards goals, and outcomes achieved. These should be subject to regular audit.

Recommendation 3:
All paperwork relevant to an individual's episode of care must be retained in the individual's care record and be readily accessible to staff.

Recommendation 4:
Managers should review the provision of psychological therapies in the IPCU to ensure individuals receive an appropriate level of psychological assessment and intervention in line with their clinical needs.

Recommendation 5:
Managers should review occupational therapy provision in Affric Ward to ensure equitable access across the hospital and to support a more integrated assessment of individuals' functioning and recovery needs.

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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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