

**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Ward 4, Dr Gray's Hospital,  
Pluscarden Road, Elgin, IV30 1SN

**Date of visit:** 11 September 2018

## **Where we visited**

Ward 4 in Dr Gray's Hospital is an 18-bedded acute psychiatric admission ward for adult and old age psychiatric patients. The ward also occasionally provides care and treatment for young people and patients with a learning disability. We last visited this service on 31 October 2017 and made no recommendations.

## **Who we met with**

We met with and reviewed the care and treatment of seven patients.

We spoke with the service manager, the charge nurse and other clinical staff.

## **Commission visitors**

Douglas Seath, Nursing Officer

Claire Lamza, Nursing Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

The patients we spoke to reported that staff were approachable, supportive, and always available for patients to talk to. The atmosphere in the ward was calm. Patients seemed comfortable in the company of staff and happy to approach them. We saw staff being very proactive in engaging with patients. All interactions we saw were warm, friendly and respectful.

When reviewing the patients' care plans we noted that useful and detailed initial assessments were completed within 24 hours of admission and were of a high standard. However, we found variation in terms of the quality and completion of the interventions in care plan documentation. We also saw evidence of good risk management. Risk assessments had a clear history, triggers, coping strategies, methods of de-escalation, and safety plans that had evidence of review.

We noted that patients were being well-supported to attend and participate in the ward review discussions, for example receiving assistance to write down what they would like discussed in advance of multi-disciplinary team (MDT) meetings, and nursing staff spending time with patients providing feedback from the discussions following the meetings.

Access to occupational therapy, psychological therapies, and physiotherapy were available but were not part of the core MDT. Most of the patients who accessed clinical psychology only did so following a lengthy referral, although we reviewed the cases of at least two patients who we felt could have benefitted from psychological therapies input.

There was good attention to physical healthcare needs, including a full medical assessment on admission with regular physical health checks, monitoring, and referral to specialist services if required.

Staff have developed an observation prescription sheet, helpful in determining when this is reviewed. But the form was not always present in files. There was also a pilot of recording agreed time out from the ward which seemed to be going well and would alert staff if someone had overstayed the agreed return time without informing the ward.

Two patients had complained of 'strong-arm techniques' used by staff in situations requiring use of restraint. There was nothing to indicate staff had not followed agreed protocols but we could not easily find evidence of review or notification documentation recording particular incidents mentioned.

### **Recommendation 1:**

Managers should review the provision of psychological therapies to the care provision in the ward.

### **Recommendation 2:**

Managers should ensure that care plan interventions are detailed and measurable in order that goals can be seen to have been achieved.

## **Use of mental health and incapacity legislation**

We interviewed two patients who were subject to detention under the Mental Health (Care & Treatment) (Scotland) Act 2003 ('The Mental Health Act'). One was subject to a Short Term Detention and the other a Compulsory Treatment Order. Unfortunately, we were unable to locate the documentation on file to support the authorisation of their detention.

Consent to treatment forms ('T2' and 'T3') were in place, however, and all treatments were compliant with the medication authorised.

### **Recommendation 3:**

Managers should ensure there are copies of Mental Health Act forms, to authorise detention in hospital, available in patient records at all times.

## **Rights and restrictions**

The door to the ward was unlocked and patients could come and go freely. However, at least one patient we spoke to who was admitted on a voluntary basis was unsure whether he was at liberty to leave and said he felt 'imprisoned' in the ward. He had been out with a nursing escort but was unclear as to his detention status.

However, on discussing the matter with staff, it is evident that patients are given information regarding status on admission and this documentation is available at their bedside.

Patients were able to make cups of tea and coffee or make snacks when they wished.

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/media/369925/human\\_rights\\_in\\_mental\\_health\\_service\\_s.pdf](https://www.mwcscot.org.uk/media/369925/human_rights_in_mental_health_service_s.pdf)

### **Activity and occupation**

There was no occupational therapy input to the general ward activity programme. Any activities provided was entirely the responsibility of nursing staff and could prove difficult to maintain when other clinical activity duties needed to take precedence. There was evidence of music therapy with one patient and artwork on display produced by patients during art therapy sessions, but these were no longer available.

### **Recommendation 4:**

Managers should make provision of activities in the ward which is not dependent on nursing staff freeing up time from clinical duties.

### **The physical environment**

The ward was in fairly good decorative order comprising two dormitories and single rooms. Patients had no direct access to a garden, with the ward being situated on the first floor. However, patients could access a sensory garden in another part of the hospital. The ward did have space for activities such as pool, table tennis, and a gym, giving ample scope for exercise within the building. There was also space for meeting relatives and a quiet space if patients wanted to sit apart from others.

### **Any other comments**

Closure of a stepdown service providing rehabilitation accommodation for patients discharged from hospital is having an adverse effect on the ability of the ward staff to resettle patients back into the community. This has led to patients having to be housed outwith the Moray area with the result that a different care team has to be introduced.

## **Summary of recommendations**

### **Recommendation 1:**

Managers should review the provision of psychological therapies to the care provision in the ward.

### **Recommendation 2:**

Managers should ensure that care plan interventions are detailed and measurable in order that goals can be seen to have been achieved.

### **Recommendation 3:**

Managers should ensure there are copies of Mental Health Act forms, to authorise detention in hospital, available in patient records at all times.

### **Recommendation 4:**

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## **Good practice**

The information pack and guidance for informal patients is highly commendable.

## **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

Alison Thomson, 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 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@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)

website: [www.mwscot.org.uk](http://www.mwscot.org.uk)

