

**Mental Welfare Commission for Scotland**

**Report on an announced visit to:**

New Craigs Hospital, Affric (IPCU) and Bruar wards, Leachkin Road, Inverness IV3 8NP

**Date of visit:** 2 August 2017

## **Where we visited**

Bruar Ward, New Craigs Hospital, is an 8- bedded, mixed sex, locked rehabilitation unit for patients, some of whom may have come to psychiatric services through contact with criminal justice.

We last visited this service on a local visit on 17 March 2016 and made no recommendations.

Affric Ward, New Craigs Hospital, is a locked intensive psychiatric care unit (IPCU). The IPCU is low secure and has 10 beds. We last visited the service on a local visit on 24 November 2016.

We made the following recommendations:

1. Senior managers should work with the ward manager to agree how care plans will be audited, to ensure consistency is achieved re quality of information documented and timescales for review.
2. A record should be available which clearly shows when individuals have been engaged in activities and also when the offer has been made but declined.

The general manager has reported progress on these recommendations. A mental health record keeping and care planning audit tool is being used to regularly audit care planning documentation on the ward to improve standards and consistency. They have also involved the Scottish Recovery Network, and are now using the Scottish Recovery Indicator Tool II. Ward activities are now planned on a daily basis. Clearer recording of, if and when patients are offered, take part in, or refuse to take part in activities is kept, including additional ad hoc activities.

## **Who we met with**

We met with and/or reviewed the care and treatment of nine patients and met six relatives.

We spoke with the general manager, and the senior nurses for both wards.

## **Commission visitors**

Tony Jevon, Social Work Officer

Claire Lamza, Nursing Officer

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

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

In Bruar Ward, one of the relatives spoken with on the day was very positive about the treatment provided by the service, in terms of the person-centred care provided by both medical and nursing staff. This relative and one of the individuals we met with on the day explained that the multidisciplinary team actively involve relatives in reviews, arranging video conferencing and transportation which supports family involvement. One of the individuals was very positive about the type of care provided in Bruar, which they felt was helpful to their needs.

One patient's relatives told us they did not think sufficient weight was given to their views regarding treatment. However, they were positive about the nursing care on Bruar and were involved in discharge planning.

All of the relatives seen in the intensive psychiatric care unit (IPCU) were positive about the care and treatment being provided. They did not raise any significant issues about the inpatient service although finding suitable resources in the community for individuals with complex needs was raised by several relatives. The clinical team and hospital management were aware of these problems and were trying to address them appropriately with community colleagues.

The care plans were organised and information was easy to find and current. The weekly ward round document, along with comprehensive minutes of regular care programme approach meetings gave a clear account of how care and treatment is planned and delivered. There was clear evidence of input from a multidisciplinary team that included medical and nursing staff, occupational therapist technicians and social workers. There was also evidence of independent sector services active involvement in the ongoing care of individuals, whilst they were in the ward.

The care plans that we reviewed had completed 'My View' documents, which gave details of the individual's preferences and choices regarding their care. Recovery care plans were integrated into the individual's treatment goals and progress documents. Feedback from the previous Commission visit in 2016 requested that the objectives and actions were differentiated, numbered, referenced in reviews and progress was commented on. This was evident in the care plans that we reviewed.

There was a clear focus on rehabilitation; all individuals in Bruar are encouraged and supported to build skills in establishing a structured routine. This appeared to be an approach that all individuals participated in, however, engagement varied depending on the individual's motivation. The use of an individualised weekly planner was evident in some care plans and it is recommended that this be implemented for all in the ward.

### **Recommendation 1:**

The clinical area manager, in conjunction with the other members of the clinical team, should ensure that all individuals in Bruar Ward have a weekly planner outlining scheduled activities.

On the IPCU there is a developing focus on recovery, supported by the senior charge nurse (SCN) for the unit. The Scottish Recovery Indicator tool (version 2) is being used to review and develop the ethos of care in the team and in the ward. The SCN has linked in the national work on standards of care in IPCUs and finds this network useful in sharing and changing practice in Affric Ward.

There was good evidence of mental health officer involvement, and of psychology with one of the individuals that we met with, although we were advised that currently there is no established provision of clinical psychology in Bruar Ward for individuals who require forensic services. We would support this service provision being reviewed to include the needs of this particular group of individuals.

### **Recommendation 2:**

Senior managers should review the provision of clinical psychology so that there is equality in the accessibility of this service for all patients, including those who have had contact with criminal justice.

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

All individuals in both wards were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995. All documentation relating to their detention was filed in the care plan where relevant.

The individuals we met with in both units had been given information that ensured they were aware of their rights. It was recorded in the care plans where advance statements had been discussed, although the uptake on these remains variable. Advocacy and solicitors were also involved, as well as the individuals having a named person.

Paperwork relating to treatment under Part 16 of the Mental Health Act was in good order, and the relevant consent to treatment forms (T2s and T3s) authorising treatment were available.

### **Rights and restrictions**

The main doors to both wards are locked, and at the time of our visit, Bruar Ward was full. The IPCU had three vacant beds. There is a locked door policy advising individuals of why this is and we observed staff responding in a timely way to individuals' requests to leave and return to the unit.

The care plans that we reviewed contained comprehensive reports that included minutes of multi-agency public protection arrangements (MAPPA) meetings, HCR-20 risk assessments and social circumstance review information; this information was then used in the risk management and treatment goals in each individual's care plan.

We reviewed the documentation for one specified person in detail and found some confusion over the restrictions that were being applied. This was resolved very quickly.

### **Activity and occupation**

The recovery model is being used to underpin activities in both wards. In Affric Ward, Saturday morning community meetings have been helpful in identifying new ideas such as the installation of personal blackboards in patient rooms for individuals to use creatively as a recovery tool. The necessary equipment has already been acquired and this idea should be implemented in the near future.

In addition to the ongoing structured routine provided by the occupational therapist (OT), the OT technical instructors and ward staff, including the nursing assistants that includes outings, walking and walking football, new additions include music groups, film nights and gardening projects that have been developed as part of the activity schedule of the ward.

The secure garden area is a work in progress and individuals in Affric Ward are actively engaged, coming up with ideas about improving the space and in the actual work involved to do this.

Bruar Ward supports individuals to budget for their meals, cook these themselves, attend to their laundry and manage personal space. All individuals had their own room with personal belongings as well as having a range of activities around the hospital and in the community. There was good evidence of individuals building skills, e.g. accessing meaningful activity, such as working as volunteers or in learning to access public transport for pre-discharge visits home.

There are links to the activities provided by the social centre in the main hospital building and the ward offers different types of either group-based or more tailored one to one activities. There is an activity room in the ward that individuals can access.

The individuals that we met with are encouraged to access a variety of activities, although they did not always choose to engage in them. We consider that it would be helpful to identify and document when an activity is offered but not engaged in. There were also those who had a specific interest in cycling, although we were advised that this was only facilitated with staff support. We suggested that with a risk assessment this could be integrated into the individual's activity plan.

### **Recommendation 3:**

Staff should record when an activity is offered to an individual and when the individual chooses not to participate.

### **Recommendation 4:**

The clinical area manager should ensure that risk assessments for specific activities are undertaken that support individuals' participation in the activity of their choice.

## **The physical environment**

In the IPCU there was an issue with the smell of cigarette smoke coming into the main day area. We raised this with the SCN who explained that they were trying to accommodate one individual who had physical health problems that posed a risk of falls, but who also smoked. We suggested that the team consider other ways in which the individual could access the smoking area, but was not at risk of injury.

The environment appeared a little worn in some areas, although some parts were redecorated in the last year. The SCN advised us that she hoped to improve some parts of the main areas with recovery-type art work that will support individuals who are in Affric to be engaged in their recovery journey. Again, agreement and funding for this project are in place, and work is expected to begin in the near future.

In Bruar Ward we spoke to a member of staff who told us space in the kitchen and laundry area is limited. Each individual has a small cupboard and a shelf in the fridge for their items.

There was a pleasant room for interviews, a separate activity room set up with keyboard and other items for use, a main day area and separate dining space. The ward was homely and well presented.

No issues were raised by any of the individuals that we met with regarding the environment.

## **Summary of recommendations**

1. The SCN, in conjunction with the other members of the clinical team, should ensure that all individuals in Bruar Ward have a weekly planner outlining scheduled activities.
2. Senior managers should review the provision of clinical psychology so that there is equality in the accessibility of this service for all patients.

3. All staff should record when an activity is offered to an individual and when the individual chooses not to participate
4. The SCN should ensure that risk assessments for specific activities are undertaken that support individuals' participation in the activity of their choice.

### **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.

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