Mental Welfare Commission for Scotland

Report on announced visit to:

Aonach Mor, New Craigs Hospital, Benula Road, Inverness, IV3 8EL

Date of visit: 29 August 2023

Where we visited

Aonach Mor is a 14-bedded rehabilitation unit divided into three separate flats located in a suburb of Inverness; all the beds were occupied on the day. The flats are self-contained, but all are similar in layout and are mixed sex with no distinction in terms of function. Aonach Mor staff provide assistance to patients with building practical skills related to independent living and education regarding their mental and physical wellbeing towards recovery. One-to-one sessions with staff members are individually tailored to patients' needs and provided by nursing staff and occupational therapists (OTs).

We last visited Aonach Mor in August 2022, where we made recommendations about specified persons documentation, section 47 of the Adults with Incapacity (Scotland) Act 2000, treatment plans being completed, and the admission protocol for the ward.

On the day of this visit we wanted to follow up on the previous recommendations.

Who we met with

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

We spoke with the hospital manager, the charge nurse, the clinical director, and the nurse manager.

Commission visitors

Douglas Seath, nursing officer

Justin McNicholl, social work officer

What people told us and what we found

Most of the patients we met with during our visit spoke highly of the staff in the ward and were appreciative of the care, treatment, and support they had been receiving. We heard that staff were approachable and listened to patients' concerns. Nurses were described as welcoming, caring and helpful and those patients we spoke with told us that they had good relationships with them. One patient commented "I don't know where I would be without them". During our visit, we saw staff communicating and interacting warmly with patients in the unit.

Managers acknowledged there have been staffing difficulties, particularly with the recruitment of registered nurses and this could impact on provision of activities. Regular use is made of agency staff, but managers felt that there was a good prospect of positive recruitment from the new graduates applying for posts in autumn 2023. There was evidence of input from psychology, with psychological formulations being undertaken, and outcomes shared with the multi-disciplinary team (MDT) in addition to providing individual treatment. However, the psychologist is soon to leave and there could be difficulty in finding a replacement. We will be keen to hear how this has progressed when we next visit.

Physical health screening was evident, assessments were ongoing, and care plans related to physical health needs were in evidence.

Care, treatment, support, and participation

When we last visited the service, we found care plans were not sufficiently detailed and lacked a clear link to risk assessments. During this visit, we found person-centred care plans, but they did not always evidence patient involvement. In addition, it was good to see that discharge care plans were in place, where appropriate. When we reviewed the care plans, we were able to locate detailed daily entries. However, reviews did not regularly target specific nursing interventions and level of individuals' progress against objectives. While care plans were in place for each patient, we would like to have seen more detail relating to goals and interventions which had been agreed with patients. We would also like to have seen more evidence of how those goals were considered and how patients were involved in the process, or of the attempts that have been made to do so, recorded in patient records. Whist there was evidence of reviews being undertaken, these were not consistent in nature or frequency.

Many of the individuals in Aonach Mor are subject to the Care Program Approach (CPA). CPA is a framework used to plan and coordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery uppermost. We noted that these meetings were held on a regular basis and were clearly recorded, with timely outputs covering all key areas. We were pleased to see evidence of patient and carer participation at these.

We found that a helpful format had been used to record MDT meetings and this covered most aspects of care and treatment, including the use of the Mental Health (Care & Treatment) (Scotland) Act 2003. In view of the level of severe and enduring illness in the patient group, we thought that it could be further enhanced by having reference to Adults with Incapacity (Scotland) Act 2000 issues. Where patients were subject to welfare guardianship under the AWI Act, we found copies of the powers on file.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Managers should ensure that care plans are person-centred, demonstrate patient involvement, and have clear evidence of goal setting, interventions, and review.

Use of mental health and incapacity legislation

Many of the patients in the unit were detained under the Mental Health Act or the Criminal Procedure (Scotland) Act 1995, (Criminal Procedure Act). Paperwork relating to the Mental Health Act was filed appropriately and was easy to access in the files. The patients we met with during our visit had a good understanding of their compulsory status where they were subject to detention under the Mental Health Act.

We reviewed forms for consent to treatment under part 16 of the Mental Health Act (T2 and T3 forms). Part 16 sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. We found that all T2s had been completed by the responsible medical officer with a record of patient consent. The forms were located with the medicine prescriptions and were up-to-date.

Where an individual lacks capacity in relation to decisions about any medical treatment, a certificate completed under section 47 of 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. All s47 certificates were in order and had appropriate treatment plans to accompany them.

Rights and restrictions

Aonach Mor has an open door policy and all patients have free access to their rooms and the ability to come and go from the unit. 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 a patient is a specified person in relation to this, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would expect restrictions to be legally authorised and the need for specific restrictions regularly reviewed. We were informed that no individuals currently in Aonach Mor had been made a specified person.

The ward had good links with the local advocacy service, though uptake with this service appeared to be low. From the files that we reviewed; we were able to see where patients had support from an advocate.

When we were reviewing patients' files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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 only located one and it appeared to have been made many years previously.

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/law-and-rights/rights-mind

Recommendation 2:
Rehabilitation units are an ideal location to discuss writing advance statements with patients, and managers should make discussion of these an important part of the admission process.

Activity and occupation

We were pleased to hear that relationships were being re-established with community resources. We heard how everyone has a personalised activity programme which is tailored to their interests, including access to Green Space groups, New Start, Branching Out Hawthorn Gardens. There were limited activities in the unit, but patients enjoyed Chi Gong, nature groups, walking groups, as well as shopping outings and cooking meals.

The physical environment

The layout of the unit consists of 14 self-contained flats. There are several communal areas and a spacious garden. Unfortunately, the exit to the garden means one of the sitting areas is a thoroughfare. The environment was calm and bright, though the décor was tired and in need of upgrading.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plans are person-centred, demonstrate patient involvement and have clear evidence of goal setting, interventions, and review.

Recommendation 2:
Rehabilitation units are an ideal location to discuss writing advance statements with patients, and managers should make discussion of these an important part of the admission process.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication of this report.

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 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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