Mental Welfare Commission for Scotland

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

Date of visit: 16 October 2024

Where we visited

Ward 4 in Dr Gray's Hospital is an 18-bedded acute psychiatric admission ward for adults. The ward also provides admission to older adults, young people and individuals with a learning disability and/or autism who have a mental health diagnosis.

On the day of our visit, there were 21 individuals in the ward, however three of those were out on pass. Managers informed us that they had continued to use surge beds since our previous visit, due to the needs of the service.

We last visited this service on 17 and 18 October 2023 as part our series of visits to the more rural adult acute inpatient admission wards. We made nine recommendations on the previous visit, and we received a detailed action plan as to how the service planned to meet them. Recommendations were made with regards to the standard of documentation, care plans, multidisciplinary team (MDT) meeting record, psychology provision, patient information board, Adults with Incapacity (Scotland) Act 2000 (the AWI Act) documentation, individuals' time out of the ward, and activity provision.

On this visit we wanted to find out how the service had implemented the recommendations, and we also wanted to view the ward environment. We had continued to make recommendations with regards to the Ward 4 environment on our previous visits and had been informed on our last visit, that the plan was for the ward to decant to another area in order for the works to be done. However, we received an update from the interim chief officer of Moray Health and Social Care Partnership (HSCP) earlier this year to inform us that these plans were not going ahead, due financial constraints.

Who we met with

We met with five individuals, reviewed three of their care records and reviewed a further four care records. We spoke with three relatives/carers.

We spoke with the senior charge nurse (SCN) deputy charge nurses (DCNs), other nursing staff, the recovery nurse, the consultant psychiatrist, the lead nurse, and the acting clinical nurse manager.

We also made contact the local advocacy service and the Moray Wellbeing hub prior to the visit.

Commission visitors

Tracey Ferguson, social work officer

Dr Sheena Jones, medical officer

What people told us and what we found

Care, treatment, support and participation

Most of the individuals in the ward had been admitted for assessment within the previous two months of our visit, apart from four individuals, where their stay was longer. Since our previous visit, we were pleased to hear that there had been a few discharges from the ward for individuals who had been delayed in hospital for a significant period of time. We were also told of discharge plans for others and heard that some delays were due to resources, such a care packages or care placements.

Individuals we met with were all at different stages of their recovery journey and again, on this visit, we saw the various levels of acuity in the ward, along with some complex care needs.

We received mixed feedback from individuals about their experience. Most individuals described staff as caring, good and helpful. However, some people told us that the staff tended to spend a lot of time in the office and were often on their mobile phones. This comment was also made by some relatives we spoke with. Quite a few people told us that their time on the ward was “boring” as there was not enough to do. All the relatives we spoke with told us that there was lack of activity provision.

Everyone we spoke with told us that they had not seen their care plan. However, everyone knew about the weekly multidisciplinary team (MDT) meeting, that they were happy with their current care and treatment and had the opportunity to meet with the consultant psychiatrist regularly, making them feel involved in decisions about their care and treatment. One individual told us that the doctor explained things in really simple terms to them, which they found helpful.

Some individuals told us about the regular one-to-one meetings they had with staff and the recovery nurse and how they found these sessions helpful. However, this was not the case for everyone. One individual told us that they felt “left to get on with it” and “it was really up to me to get better”. Whilst another individual told us “the nurse would just look in the door to do their checks and not do any more than that”.

Most individuals told us that they felt safe in the ward and that it was a place where they got better. However, we heard from a few individuals that their safety and privacy was compromised due to there being no locks on some doors, including toilet doors.

Some individuals were able to tell us about the progress with their discharge planning and how the time out of the ward on passes was aiding this. Individuals who were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) were aware of their rights and told us about their involvement with advocacy.

Most individuals described the food as “awful”. We had a discussion with staff about this as this seemed to be a new concern. We were told that due to ongoing refurbishment, the food was coming from another area, but that this was only temporary.

Feedback from carers and relatives was mixed. Carers/relatives told us that the communication was inconsistent, and one described feeling involved, as they were invited to the MDT meeting, but another person told us that they had not been invited, consulted or involved.

All carers/relatives told us that they were unsure what to expect when their relative was admitted to the ward. Disappointingly, none had been given the carer’s leaflet, which was devised in 2021 by the ward and Moray Wellbeing Hub. From our previous visits, we were aware that the ward was looking to develop an information booklet in conjunction with the Moray Wellbeing hub, which could be given to those admitted to the ward. We were informed last year that this had not progressed due to other pressures in the service, and we found this was still the same on this visit.

In terms of staffing, the SCN told us that since our last visit, the ward has had to continue to frequently use agency staff in order to provide sufficient cover in the ward and this has mainly been due to high staff absence.

We were told that where an individual had a diagnosis of dementia, they would likely be transferred to Muirton ward, which is a specialist ward in Seafield Hospital for people with a diagnosis of dementia. However, we were aware from the Commission’s visit to Muirton ward earlier in the year that the ward continued to also operate at full capacity, which at times has had an impact on transfers.

Care records

We were aware from other visits across NHS Grampian that the electronic system TRAKCare was being rolled out; this was the case for this visit. We were told that all the ward-based staff and the ward consultant psychiatrist recorded all daily contact with individuals on this system and that the weekly MDT meetings were also being recorded on TRAK.

We accessed individual electronic care records on the day of the visit, as well as paper files that continued to be place. The SCN told us that the plan was for the ward to eventually have all recording and documents transferred over to the electronic system. It was positive to hear that the ward was now using an integrated system, as opposed to multiple recording systems.

Nursing care plans

We wanted to find out how the ward had improved on the completion of the documentation from our last visit.

We were told that the team leaders now completed monthly audits and that any issues would be highlighted back to the team via a safety brief, staff handover or to the individual staff member. We received a copy of the audit tool which was a 'tick box' document and mainly covered aspects of the Nursing and Midwifery Council (NMC) standards relevant to record keeping for nurses. We were satisfied that the ward had implemented these audits in order to improve record keeping. As the ward were now using the electronic system, we heard from the team leader that there was a plan to review the tool.

From the individual files we reviewed, we found nursing assessments completed on admission, along with a risk assessment and risk management plan. However, we found that completion in many of these documents was variable and all risk reviews only recorded 'remains relevant'. We reviewed records where there was evidence that the risks had changed and concerningly, the reviews did not reflect these changes.

Recommendation 1:
Managers must ensure that all risk assessments are regularly reviewed, updated, and discussed in the MDT meeting to ensure they accurately reflect the individual's assessed risk and that an agreed risk management plan is formulated.

We did find that daily entries by nursing staff were relevant, detailed, meaningful and provided good information of progress updates about the care and treatment of the individual, along with incorporating individual views. We saw that regular one-to-one meetings between the nursing staff, recovery nurse and individuals were taking place, as well as regular meetings with their consultant psychiatrist. We noted that the daily recording process had improved and records and updates about individual care were legible. All professionals providing input to the ward were now using the same system, instead of separate recording systems.

We wanted to find out how the ward had taken forward the recommendation that we made on last year's visit about the care plans. We spoke to the SCN and team leader and were told that there had been mini audits undertaken.

The care plans were still being completed in paper format and kept in the individual's care record. There was one individual who had a continuous intervention care plan in place and this care plan was detailed with evidence of ongoing review.

Unfortunately, on reviewing the care plans we did not find any improvement. The level of detail in the care plans was variable. Whilst some were reasonably detailed, and person-centred, others lacked important details. We found care plans that were not holistic and did not cover the range of physical health issues required for the people that we reviewed.

Some individuals had specific personal and financial needs, that were not covered in these plans.

The care plans that we reviewed had no regular meaningful reviews recorded and no evaluations that determined if the current care plan was working; it was difficult to know what progress the individual was making in their recovery or what the staff's reflection was as to whether the care plan was working or not. We found updates in other documentation that was not reflected in the care plans.

Similar to last year's visit, it was difficult to know about the involvement and participation of individuals. Many care plans were not signed and left blank, where others had recorded at the time of admission that it was not appropriate to discuss or ask the person to sign. There did not appear to be a process in place to revisit this at various times throughout the individual's journey. This reflects what people told us about not seeing their care plans or being involved in them.

We were concerned to find no progress with regards to the care planning documentation and processes and therefore repeat this recommendation. We discussed this further with the managers on the day of the visit and made them aware of the progress that had been made in other areas of Grampian to improve care planning documentation and suggested that they linked in with these areas.

Recommendation 2:
Managers should ensure that there is a regular audit process in place in order to improve the quality of care plans to ensure that they reflect and detail interventions which support individuals towards their care goals, along with regular reviews, summative evaluations, and evidence individual and carer involvement/participation.

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)
We were told that since our last visit there was now only one consultant psychiatrist that covered the ward, as opposed to the six previous consultants. Staff told us that this was an improvement, particularly with communication and continuity. The MDT meeting continued to take place twice weekly, and the core MDT consisted of the consultant psychiatrist and nursing staff.

We were told that the ward continued to have access to allied health professionals (AHPs), such as occupational therapy (OT), physiotherapy, dietetics, and psychological services via a referral system. However, on this visit, we again found that there were several individuals in the ward who would have benefitted from psychology input due to the complex presentations, which staff agreed with.

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

Medical staff told us that they had referred individuals to psychology services however, referrals were not actioned. We were provided with an example where an individual had commenced psychology input in another ward however, once they transferred to Ward 4, this did not continue due to the ward having no dedicated psychology provision.

We wanted to find out how the service had progressed the recommendation about psychology provision since our last visit. Managers told us that this had been escalated to senior managers and that inpatient referrals would take priority, however, this was not what we found on the day of our visit. We have consistently raised concerns regarding individuals' access to psychological services on our visits since 2018.

Recommendation 3:
Managers must ensure that there is psychology provision available to the individuals in the ward.

We were told that OT were not part of the core MDT and did not have input into the general ward activity. We were told that OT input would usually commence with an individual prior to discharge, where appropriate.

The ward had no regular input from pharmacy.

The ward staff were having to manage a diverse group of individuals, some with a variety of complex needs. Nursing staff were therefore required to have a vast range of skills and knowledge. It was disappointing that the ward continued not to have in place a full range of MDT professionals to provide care and treatment and support each person's recovery. We were told that there could be difficulties in progressing individual discharges due to their complexity, but we were also told that managing certain presentations on the ward, in the current environment was challenging.

We wanted to follow up on our recommendation last year about the MDT meeting record. A record of the MDT meeting was now completed on the electronic system. The electronic MDT meeting record provided a detailed overview and update of the individual's care and treatment and recorded who attended this meeting, along with outcomes and actions. We found the new electronic recording format to be more robust and covered all necessary aspects of a person's care and treatment, including capturing their views. The new format enabled prompts to review treatment and provided detailed information with regards to physical health care monitoring.

Nursing staff told us that they were getting used to this new recording format and the leadership team told us that the more the electronic system was being used, it was apparent that there were some areas that may require to be improved. We were pleased to hear that the staff had adapted well to this, and we found the recordings to be detailed.

Individuals were supported to attend and participate in the meeting if they wished to, or they had opportunity to meet with their psychiatrist before or after the meeting. We saw where their views were sought and incorporated into the record.

Managers told us that there continued to be active social work and mental health officer involvement at various stages in the MDT process of an individual's admission.

Nursing staff and the SCN told us that they continued to receive fortnightly clinical supervision by the psychotherapist, which they felt was of benefit to them.

Use of mental health and incapacity legislation

On the day of the visit, 12 individuals were subject to detention under the Mental Health Act, and we found that the detention paperwork was in order and easy to find in the paper record.

The ward had recently moved to the electronic prescribing system, HEPMA (hospital electronic prescribing and medicines administration) and the SCN told us that the staff had managed this transition well.

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. All treatment certificates were kept in individuals' files and were easily accessible. We found several issues with consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We found that one individual's authority to treat certificate had expired in 2018 and this was only picked up on admission to the ward from community mental health services.

Last year, the Commission published the themed visit report; *Compulsory treatment for mental illness in the community – how is it working?*[2]

One of the recommendations in the report was regarding legal authority under part 16 of the Mental Health Act. We had received a response as to how services were going to meet this recommendation and will link in with senior managers of Moray HSCP.

On our visit last year, we were concerned to find that 'as required' intramuscular (IM) medication had been prescribed for two individuals who were not detained under the Mental Health Act. Administration of 'as required' IM psychotropic medication almost always requires the legislative authority of the Mental Health Act. The Commission is also concerned when IM 'as required' medication is being prescribed

[2] Compulsory treatment for mental illness in the community: https://www.mwcscot.org.uk/node/2173

for informal individuals, who are not detained under the Mental Health Act. This is because it is unlikely that there would be consent to receive this treatment if it had to be administered in circumstances where restraint may be required.

We were pleased to see that no informal persons had been prescribed or administered 'as required' IM medication. However, we did find that 'as required' IM medication had been recorded on a T2 certificate, which we would consider to be inappropriate. This is because any advance consent the individual had given is invalid if they have withdrawn their consent at a later time when the medication is given or if restraint is involved.

We will continue to follow up on these matters with regards to treatment issues with the clinical lead and consultant psychiatrist to ensure these matters are addressed urgently.

Recommendation 4:
Managers must ensure that all psychotropic medication is appropriately and legally authorised and that regular audits undertaken to ensure improvement in this area is maintained.

Recommendation 5:
Managers must ensure that the ward has regular input, support and provision from pharmacy.

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 (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.

There were two people with section 47 certificates in place, along with a treatment plan. We discussed one individual's certificate with the consultant psychiatrist. This individual was detained under the Mental Health Act and had a T3 certificate in place, as they were assessed as not having the ability to consent to treatment under Part 16 of the Act. However, the AWI Act treatment plan included treatment for mental disorder which was authorised under the Mental Health Act. The consultant psychiatrist agreed to review this certificate.

We found relevant paperwork for individuals who were subject to welfare guardianship orders under the AWI Act.

There was a white board displayed on the wall in the staff clinical area, that could be viewed from the ward corridor. This board recorded individual's details and we were told that this was to provide a quick overview for staff. We were concerned about

this board on our last visit, as the board was not kept up to date and contained inaccurate information. Although information on the board was accurate on the day of our visit, it was difficult to decipher information, due to the size of the board and the amount of information that was trying to be incorporated.

We made a recommendation last year for managers to purchase a new patient information board and to ensure that pertinent information was recorded accurately.

We received information on the returned action plan that the request was being made to senior managers for a new board to be purchased, which would be relocated to the preparation room, in order to maintain confidentiality. We were satisfied with this response however, on the day of the visit the same board was on the wall, in the same location, and able to be viewed by others. The service has made no progress in relocating this board or purchasing a cover or blind for it. We were told that there had been discussions about getting a screen, and it was hoped that the ward would get approval for this. However, a year since our last visit, and we remain concerned that no action had been taken. This recommendation will therefore be repeated.

Recommendation 6:
Managers should provide a new patient information board that is large enough for staff to record all pertinent information clearly, including demographic details and legal status and that the board should be kept in an area that protects individuals' confidential information.

Rights and restrictions

The door to the ward was open on the day of the visit and the SCN told us that although the ward had an open-door policy, at times due to the risk or safety of an individual, a decision is made to lock the door for short spells of time and that individuals are informed of this.

S281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on individuals who are detained in hospital. Where a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied, and the appropriate paperwork is completed.

We found issues with specified person paperwork for two individuals where they had been made specified for telephones; we could not locate the required RES3 form in the file. We also found that restrictions were in place for two individuals, where it was recorded on the reasoned opinion document that this was to manage their finances, under safety and security measures. For the safety and security measures to apply, the RMO has to determine that "the person has sought to acquire or is likely to seek to acquire, any item which is likely to be prejudicial to the health or safety of

any person or to the security or good order of the hospital". It is therefore the Commission's view that managing a person's finances is not authorised by this legal framework.

We will follow up with managers to ensure that appropriate action is taken from this visit.

We were disappointed to find that not all paperwork was in order, as we had made a recommendation about this on our visit in 2022. We were told that the service would meet this recommendation through regular audits and would be reviewed as part of the MDT, however this had clearly not been maintained.

Recommendation 7:
Managers should ensure that for those individuals where specified persons procedures are implemented that the relevant paperwork, including reasoned opinion is completed, reviewed and audited.

The Commission has produced good practice guidance on specified persons[3].

When reviewing files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under section 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. Health boards have a responsibility for promoting advance statements.

We did not find any advance statements in the files we reviewed and did not find any indication that they were promoted at any stage throughout the admission process. We had a further discussion with managers about advance statements and how the use of advocacy services could support individuals with this and also the importance of staff continuing to promote their completion at stages throughout admission.

Recommendation 8:
Managers should ensure that they promote advance statements across the service and that these are discussed at various points in the individual's admission.

We wanted to follow up on our recommendations last year about individuals' time out of the ward (TOW). Managers told us that the TOW document would be modified to include individuals' views, whether they were receiving treatment formally or informally and information would be documented in the nursing records and risk management plan. We were also told that these documents would be monitored by the SCN and the deputies.

From reviewing the records, the document had not changed since our last visit and individual views were not being recorded. We were shown a copy of the new

[3] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

document which had been devised, but were concerned that more than a year later, this had not been implemented and no changes had been made.

In this time the ward had moved to electronic recording and therefore TOW was a prompt on the electronic MDT record; the ward needs to consider the best way forward to record TOW for all individuals.

The Commission has developed *Rights in Mind.*[4] 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 ward had a games room which individuals used to play pool, table tennis, and there was some gym equipment. Some individuals told us that they enjoyed playing table tennis and we saw this on the day of our visit. However, most individuals told us that there were not enough activities to do, which often led to boredom. This was similar to what we heard on the last visit.

The ward had a recovery nurse in place, and we heard about the benefits that this role had brought to individuals recovery following admission to the ward. However, the recovery nurse was often pulled into the floor numbers for the day due to staff shortages. Individuals told us about these sessions and of the benefit of them but felt that they did not happen regularly and people were unsure when the sessions would take place.

Senior managers previously told us that they were in the process of recruiting for an activity co-ordinator to work between Ward 4 and Muirton Ward. However, we have now been told that due to financial constraints, a new post will no longer be authorised.

We spoke with the recovery nurse on the day who told us that they continued to receive supervision from the psychotherapist, which was beneficial and that they had done specific training around psychological therapies, such as cognitive behaviour therapy, and dialectical behavioural therapy. Their plan was to offer appointments to individuals to identify therapeutic interventions which would support their recovery and then set times for regular meetings. Unfortunately, this was challenging, as the activity nurse continued to be counted in the daily staffing numbers when needed, so could not plan to offer consistent and regular meetings with individuals.

Some individuals had involvement with the Scottish Action for Mental Health (SAMH) service, where they would receive input in the ward or out in the community.

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

We had a discussion with managers on the day about activity provision and wondered if activity provision was discussed at the morning handover. On the day of our visit there were ample staff on the ward, but still no activity programme in place. We also found that staff spent large periods of time in the office, and we wondered since the appointment of the recovery nurse, if the culture had become that activities were viewed as being solely the role of the recovery nurse.

As the recommendation around activity provision has not been met, it will be repeated.

Recommendation 9:
Managers should ensure an activity programme spanning seven days of the week is offered and also give consideration to protected supernumerary time for the recovery nurse role.

The physical environment

The ward comprised of dormitories and single en-suite rooms. The ward had a kitchen where individuals could access tea/coffee making and washing machine facilities, if they wished. Some individuals told us that there was a communal fridge where they could store food, as an alternative to the hospital food. However, we were told that access could be difficult due to some people's excessive usage of the fridge. We discussed this further with staff on the day, who were aware of this issue and were looking at ways to address it.

We wanted to follow up on our previous recommendation regarding the environment.

We have continued to raise concerns about the environment on our last three visits and were disappointed to see that there had been no change to any of the environment on this visit. This ward does not have any dedicated garden space as it is on the first floor.

We found none of the windows on the ward opened, as they were sealed shut, providing no opportunity for fresh air into the ward. Staff and individuals told us about the poor ventilation in the ward.

Many of the bedroom and bathroom doors continued to have no locks, resulting in a lack of privacy and dignity for individuals. A number of those that we met with spoke to us about this.

There were numerous ligature points on the ward and staff told us that managing the level of potential risk this presented was extremely difficult. Managers told us that they continued to have daily discussions about managing the overall safety of the ward, however mitigating these risks was difficult due to the environment. We were told that depending on the level of individual risk, a person's admission to Ward 4 may have to be refused, meaning that the individual would have to be admitted to

Royal Cornhill Hospital (RCH) in Aberdeen. We were also told that given the pressures on the current adult mental health resources in RCH, admission and/or transfer, at times was not always timely.

Managers, nursing staff, and medical staff told us that they felt as if they were waiting on a significant incident to happen before any changes would be made to the environment.

Managers also told us that any maintenance issues on the ward or fixtures requiring attention were not prioritised and took a long time to be addressed, which concerned them. One example was the door to the activity room had been broken for a number of months and despite it being reported, the repair remained outstanding.

Since our last visit, and from previous visits dating back to 2021, the Commission has continued to request updates regarding the environment from managers of Moray HSCP. The environmental issues had continued to be escalated to the senior manager on the NHS Grampian ligature work programme and we are aware that there had been previous ongoing discussions and various option appraisals undertaken in order to progress the outstanding work since 2021.

In 2022, the Commission was concerned that no decision had been reached between Moray HSCP and NHS Grampian regarding the works that required to be completed in the ward. We continued to receive updates from the chief officer and on our visit last year we were pleased to hear that a suitable option had been identified in order to carry out the required works in the ward and that the ward would be decanted to another area for this to take place. However, we were informed earlier in 2024 that this option was no longer viable due to NHS Grampian's financial position.

Prior to our visit, we requested a further update from the interim chief officer of Moray HSCP. We have been told that a project has been commissioned by NHS Grampian's programme improvement team to review the inpatient bed base across Grampian, and that the mental health and learning disability portfolio board will consider the project proposal.

We continue to be extremely concerned about the lack of progress with regards to the environment in Ward 4. We feel it is directly and adversely impacting on the wellbeing and safety of individuals and staff on Ward 4 and also on the dignity and privacy of individuals admitted to the ward.

We will continue to request updates from the chief officer of Moray HSCP and escalate our concerns as necessary.

Recommendation 10:
Senior managers of Moray HSCP and NHS Grampian must attend to the outstanding works in Ward 4 to make this ward a safer environment for individuals and staff and ensure that their health, well-being, privacy and dignity is promoted.

Summary of recommendations

Recommendation 1:
Managers must ensure that all risk assessments are regularly reviewed, updated, and discussed in the MDT meeting to ensure they accurately reflect the individual's assessed risk and that an agreed risk management plan is formulated.

Recommendation 2:
Managers should ensure that there is a regular audit process in place in order to improve the quality of care plans to ensure that they reflect and detail interventions which support individuals' towards their care goals, along with regular reviews, summative evaluations, and evidence individual and carer involvement/participation.

Recommendation 3:
Managers must ensure that there is psychology provision available to the individuals in the ward.

Recommendation 4:
Managers must ensure that all psychotropic medication is appropriately and legally authorised and that regular audits undertaken to ensure improvement in this area is maintained.

Recommendation 5:
Managers must ensure that the ward has regular input, support and provision from pharmacy.

Recommendation 6:
Managers should provide a new patient information board that is large enough for staff to record all pertinent information clearly, including demographic details and legal status and that the board should be kept in an area that protects individuals' confidential information.

Recommendation 7:
Managers should ensure that for those individuals where specified persons procedures are implemented that the relevant paperwork, including reasoned opinion is completed, reviewed and audited.

Recommendation 8:
Managers should ensure that they promote advance statements across the service and that these are discussed at various points in the individual's admission.

Recommendation 9:
Managers should ensure an activity programme spanning seven days of the week is offered and also give consideration to protected supernumerary time for the recovery nurse role.

Recommendation 10:
Senior managers of Moray HSCP and NHS Grampian must attend to the outstanding works in Ward 4 to make this ward a safer environment for individuals and staff and ensure that their health, well-being, privacy and dignity is promoted.

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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