**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:**
New Craigs Hospital, Willows Ward, Leachkin Road, Inverness, IV3 8NP

**Date of visit:** 28 May 2025

**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

Willows Ward provides assessment and treatment for six adults who have an intellectual disability, mental health problems and behavioural issues. The ward was full on the day of our visit.

We last visited this service in May 2024 and made recommendations on ensuring there is an appropriate environment for the needs of this complex group of patients and ensuring there is a safe and effective level of consultant psychiatry support to individuals in the learning disability service.

The response we received from the service referred to a whole site masterplan to look at future accommodation when the current contract with the private provider expires in July 2025 and to the appointment of a locum consultant psychiatrist while efforts to recruit to the vacant post permanently were ongoing. We were keen to get an update on progress relating to these two recommendations.

### Who we met with

We met with and reviewed the care of four people, by talking with them in person and reviewing their care records. There were no family/carers visiting the ward on the day to speak with, but we asked the nurse team leader to tell any who visited later, or in the next couple of days, that we would be happy to speak with them.

We spoke with the consultant psychiatrist, the hospital manager, the nurse team leader, the senior charge nurse (SCN) covering from another ward and various ward staff through the course of the day. The SCN for Willows ward was on holiday on the day of our visit.

### Commission visitors

Audrey Graham, social work officer

Lesley Paterson, senior manager - practitioners

# What people told us and what we found

## Care, treatment, support, and participation

Through the course of the day, we observed warm and caring interactions from staff towards individuals. We saw that staff were engaged with individuals much of the time, supporting them in activities such as colouring in, talking with them and employing appropriate use of humour to reassure and encourage. Our impression was of a nurturing staff group who were attuned to the needs of the individuals in their care.

When individuals were asked what they thought of the care offered and of their experience of being in Willows Ward, there was a limited response from some due to their complex cognitive and communication needs and a negative response from others linked to a wish to be at home; "it's alright…aye" and "I don't like it so much" and "I prefer being in my own home in the community". We heard from one person about how they had enjoyed celebrating a birthday and saw balloons and cards in their room.

**Care records**

The care plans reviewed were held in paper files. These were person-centred and meaningful and we saw positive behaviour support plans that were up to date and with a good level of detail.

The 'Getting to Know Me' and 'At a Glance' documents had been fully completed which was particularly useful as we heard that bank and agency staff regularly provided cover. We were impressed by the use of 'Traffic Light Risk plan' documents for individuals, which set out a picture on one page of what a red, amber and green presentation looked like. It was good to hear that this approach, developed in Willows Ward was being adopted in other wards across the hospital.

We found the use of specific 'PRN Care Plan and Protocols' for individuals helpful as this offered clear guidance for nursing staff on the appropriate administration of as required medication for each individual and arguably cut down on unnecessary administration.

We noted that recording of the review of care plans was variable, and we did not see clear evidence of audit in the records.

**Recommendation 1:**

Managers should ensure regular audit of care plans takes place and is evidenced within care records.

On the previous visit, we had found easy-read versions of care plans, however we did not see these in the files that we reviewed on this visit. We noted from discussion with one individual that they had a good awareness of their care plans and felt

involved in agreeing these. We were of the view that this sense of involvement could be enhanced for others by returning to the previous practice of producing easy-read versions.

**Recommendation 2:**
Managers should include easy read versions of care plans withing care records, to enhance accessibility and the ability of the individual to actively participate in their care planning.

It was good to see that one person had a weekly planner in place, however we did think this may have been helpful for other individuals.

**Multidisciplinary team (MDT)**
Willows Ward is staffed by four learning disability nurses and six mental health nurses. We were told that there were three nursing vacancies across the service and that there continued to be a recruitment drive to fill posts, including recruitment of staff from abroad.

Staffing challenges were acknowledged by managers who advised that they are supporting current staff working at Band 3 level to qualify as registered nurses. They have two staff currently in training. We recognised that recruitment continues to be a challenge nationally. It was good to hear that the ward continued to use regular bank and agency staff to promote consistency and that they received thorough training and often felt like part of the team. We were told that once nursing staff were in post, there was a good retention rate.

It was of concern to hear that there was only one full time consultant psychiatrist in post. Following the visit last year, a locum consultant was recruited but only worked in the service from August to December 2024. Prior to this there had been a vacancy for about 14 months. From discussion with staff, we concluded that this situation is untenable and requires urgent action from hospital managers.

**Recommendation 3:**
Hospital managers must ensure that there is a sufficient level of consultant psychiatry support to patients in the learning disability service.

We were told that input from psychology was generally focused on formulation although there were two individuals receiving psychological treatment at the time of our visit. There was limited evidence of occupational therapy (OT) or speech and language therapy (SaLT) involvement through the care records. In discussion with nursing staff, we heard that they thought there should be more input for individuals. We will write to the leads for OT and SaLT to raise this.

We found that the quality of the recording of MDT meetings was variable with some templates being incomplete. Who was responsible for agreed actions and by when,

was not always recorded and full names of those in attendance was not always evident. Accountability could be improved by minor revisions to the MDT template.

**Recommendation 4:**
Managers should revise the MDT template to include a column to record who is responsible for agreed actions by when. The template should be fully completed at each meeting, including full names of all in attendance.

## Use of mental health and incapacity legislation

All individuals in the ward were detained under the under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We were told that there was no ward clerk to support the processing and organisation of statutory paperwork, however, overall, this was in good order.

Mental Health Act and Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) paperwork was accessible for each individual. Where an individual lacks capacity in relation to decisions about 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. We found section 47 certificates were present and that they had attached treatment plans.

Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place and corresponded to the medication being prescribed apart from one anomaly, which was discussed and resolved with the responsible medical officer (RMO) on the day. All T3s completed by the RMO to record non-consent were available and up to date.

Covert medication pathway documentation was fully completed but needed some increased clarity in recording of review dates. This was discussed and resolved with staff on the day.

One individual had a DNACPR document in place, however this was not fully completed in that there was no reason noted, the details of the individual's guardian were not recorded and it was not clear whether there had been discussions with the guardian. This was fed back to staff on the day.

## Rights and restrictions

We met with one individual who was nursed in a low stimuli area that had been refurbished to meet their specific needs, which was set apart from the main ward. This individual was subject to continuous intervention, having one member of staff present with them at all times. There was a detailed care plan in place to guide staff on how to deliver care to this individual. The individual was not identified as being in seclusion, but we considered them to be in seclusion given the restrictions that were

in place. We thought that the care plan was clinically appropriate but that it should have identified that the person was in seclusion and have been detailed and reviewed appropriately.

**Recommendation 5:**
Managers and medical staff should ensure that when an individual is subject to seclusion, this is identified, monitored and reviewed appropriately.

The Commission has produced guidance on the use of seclusion in health and social care setting for professionals working with individuals with mental illness, dementia, learning disability and related conditions.

We met with two individuals who had other forms of restrictive practice documented in their care plans. We heard from one individual "there's a fluid restriction in place…that's why I have to be supervised in the bathroom". We found that both individuals demonstrated an understanding of why restrictions were in place and that this understanding seemed to alleviate associated distress. We thought that these examples evidenced open communication by staff and an awareness of a person-centred approach.

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. We found that one individual was specified however the incorrect form had been used and this was resolved with the RMO on the day.

## Activity and occupation

On the day of the visit, we observed staff coming and going from the ward with individuals, into the community for shopping trips and to other parts of the hospital for activities such as cooking lunch with the OT.

We heard that activities were mainly offered on a one-to-one basis by nursing staff but there was also the option to access groups in the Social Centre which served the whole hospital. We observed that the ward had use of an iPad, there was an activity/art room with a TV, arts and crafts materials, puzzles and magazines; we heard about the opportunity for trips into the local community. It was good to hear that work was underway to put in place stronger links between the ward and learning disability resources in the community.

However, we did hear that the level of clinical activity often meant that nursing staff could not prioritise meaningful activity to support the individuals in their care. Staff advised us that the ward was relatively settled on the day of our visit.

Given the ward supports a group of individuals who are more likely to need one-to-one support to enable them to engage in activity and who are likely to have more challenges in accessing group activities, we thought that the absence of a dedicated activity co-ordinator post was a significant gap.

**Recommendation 6:**
Hospital managers should consider resourcing Willows Ward with a dedicated activity co-ordinator.

## The physical environment

The Commission has been concerned for several years that the design of Willows Ward is not suitable for this complex group of individuals. The unit sits on its own a short distance away from the main hospital and is quite isolated. We heard from staff that this makes it more challenging if they need support from other wards or to access the social centre or OT kitchen. There is no kitchen facility in the ward for functional assessments to be carried out. The ward consists of two long corridors with individual bedrooms running off these and a communal sitting area in the middle. There is an activities room at one end and the dining area is accessed off the main corridor.

We heard that the long corridors make it challenging to manage incidents where people become distressed, and noise carries through the unit which can be unsettling for others. The main office is very small and does not allow staff to observe what is going on in the ward.

There is no quiet room or sensory room and inadequate private space for visitors. The ward environment is not conducive for individuals who may have sensory sensitivities such as those with autistic spectrum disorder (ASD). We could see that staff had put thought and effort into making the best of this unsuitable environment and we thought they should be commended for this. We heard that there had been one individual in the ward for a long period whose particular needs had made it unsafe to have soft furnishings, lamps or anything decorative on display to make a softer, more homely atmosphere. This individual had moved on so efforts had been made to make the ward more pleasant and homely and also to improve the garden space. The garden fence had been painted in bright colours and there was pot plants and seating.

We saw that where it was appropriate to individual needs, people had been supported and encouraged to personalise their bedrooms. Not all bedrooms had ensuites, and we were told by staff that the communal bathroom was problematic in terms of accessibility if someone required hoisting. We thought that the conversion of this bathroom to a wet room was required. This would ensure basic care needs could be met if an individual was admitted with significant mobility issues and there was no ensuite bedroom available. We were told that the option for managing this

would be to move individuals' bedrooms around. We did not think this was advisable given the complex group, where ASD and challenges tolerating such disruption would be likely for a significant number.

It was good to hear that plans for the re-configuration of the whole hospital site were making some progress. However, we heard that it could be a further two years before Willows Ward is moved to a more suitable location, likely to be in the main building. We think it is therefore important that resources are allocated now to mitigate the unsuitability of the environment.

We would suggest that the garden area is further improved to maximise on pleasant and therapeutic outdoor space, the communal bathroom is converted to a wet room and a dedicated activity co-ordinator is recruited to increase opportunity for individuals to get out of the ward. Given individuals can be admitted to the ward for lengthy periods and substantial change is still some time away, it is thought to be important that hospital managers take further specialist advice on how else to improve the existing ward environment in the short term. The Commission will follow up these concerns relating to the environment separately with senior managers.

**Recommendation 7:**
Hospital managers must give serious consideration and agree timeous action relating to the environmental issues identified in this report.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure regular audit of care plans takes place and is evidenced within care records.

**Recommendation 2:**
Managers should include easy read versions of care plans withing care records, to enhance accessibility and the ability of the individual to actively participate in their care planning.

**Recommendation 3:**
Hospital managers must ensure that there is a sufficient level of consultant psychiatry support to patients in the learning disability service.

**Recommendation 4:**
Managers should revise the MDT template to include a column to record who is responsible for agreed actions by when. The template should be fully completed at each meeting, including full names of all in attendance.

**Recommendation 5:**
Managers and medical staff should ensure that when an individual is subject to seclusion, this is identified, monitored and reviewed appropriately.

**Recommendation 6:**
Hospital managers should consider resourcing Willows Ward with a dedicated activity co-ordinator.

**Recommendation 7:**
Hospital managers must give serious consideration and agree timeous action relating to the environmental issues identified in this report.

## 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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