Mental Welfare Commission for Scotland

Report on announced visit to:
Morlich Ward, New Craigs Hospital, Leachkin Road, Inverness, IV3 8NP

Date of visit: 15 October 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

Morlich Ward is a 12-bedded, mixed-sex ward providing inpatient care, for older adults experiencing complex, functional mental illness other than dementia. Individuals may also have diagnoses of early-stage dementia.

The ward supports those individuals whose care cannot be managed safely in the community and generally operates at full capacity. There was one younger adult admitted to the ward on the day of the visit. Additionally, there was one older adult with a primary diagnosis of dementia who was identified as being better placed in Morlich Ward due to their individual clinical needs.

We last visited in July 2024 on an unannounced basis and made recommendations relating to completion of authority to treat paperwork, provision of activities, provision of bathing equipment and bed capacity across specialties. An action plan addressing the recommendations was received from the service and we wanted to follow up on this.

Who we met with

We met with, and reviewed the care of five people, four who we met with in person and five who we reviewed the care notes of. Unfortunately, there were no family/carers available to meet with on the day.

We spoke with the senior charge nurse (SCN), the charge nurse and the service manager for older adults.

Commission visitors

Audrey Graham, social work officer

Margo Fyfe, senior manager

What people told us and what we found

Care, treatment, support, and participation

We heard that Morlich Ward continued to be used as a resource when there was pressure in other parts of the system, as was identified at our last visit. While it seemed that this was testament to the competence of the management and staff group, they were concerned about the impact on older adults who may need an admission at times when the service was full.

Overall feedback about the care and support offered was very positive. We heard that "the nursing support is excellent" and "I can't fault them…they've been very kind and considerate towards me". One individual told us that "the ward manager is amazing" and another singled out the input they had received from the physiotherapist as being "excellent". One individual who was detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) expressed how they had struggled with a loss of a sense of control but were able to look beyond this and talked of kindness shown by staff.

Throughout the time we spent in the ward, the atmosphere was calm. We observed warm and compassionate communication from staff towards individuals. People told us that they felt involved in their care, although it seemed that no-one that we spoke with had a clear understanding of what their care plans consisted of.

Care records were kept in paper form and were well organised and easily accessible. Care plans relating to physical health were generally of a high standard; they were clear and practical. Care plans relating to mental health and well-being required some improvement. Some individuals did not have holistic mental health care plans in place at all, or if they did, these were focused on behaviours such as agitation and aggression and did not consider wider mental well-being.

It was good to see a section in the support plan template prompting staff to consider 'patient/personal strengths', but this was not consistently completed. We saw some care plans where the interventions that had been detailed were wide ranging although did not link to the overarching goal.

It was good to see that reviews of care plans were taking place, but these were brief records, and we did not see from the reviews where there was consistently effected changes in the care plans.

There was some variability in the quality of risk assessment and risk management plans reviewed. Some lacked detail but others were full, clear and person-centred and linked back to the 'Getting to Know Me' document completed by the family of one individual. There were some where there was a clear link between risk management plans and care plans.

Recommendation 1:
Managers should ensure that nursing care plans are person-centred and holistic, with a clear focus on mental health and well-being and that they evidence participation of the individual and/or carer in the care planning process.

Recommendation 2:
Reviews of care plans should be regular, fully reflect the individuals' progress towards stated goals and inform the update of necessary interventions to achieve the person's goals. There should be a system of manager audit to ensure this is being achieved.

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 heard that the ward had input from five consultant psychiatrists who were generally available to meet with and review individuals one day a week. We heard that this could slow progress, with some decisions having to wait until the following week before they were made, but we were told that the plan to pilot a daily 'rapid rundown' would address this.

We saw evidence in care records of staff from across disciplines contributing to individuals' care, including physiotherapy, social work, and mental health officers (MHOs), podiatry and input from spiritual care. Occupational therapy (OT) involvement seemed to be a gap, and we heard that the OT service across the New Craigs hospital site was significantly stretched.

Recommendation 3:
Managers should review OT input to the ward to ensure individuals are receiving the full care they require.

MDT reviews were taking place, and we found the recording of some of these to be informative. It was good to see that the person's views were noted in some, although from the care records that we reviewed, there were not many that we saw which included the views of family/carers. It was good to see the involvement of various professionals as part of the MDT discussion. The section in the template consisting of tick boxes prompting review of areas such as s47, DNACPR and authority to treat paperwork was rarely completed, but represented a thorough list of significant areas which would ideally be regularly reviewed. We felt that full use of the template to guide MDT discussion would enhance rights-based care in the ward.

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

We were interested to hear about the 'Discharge Planning App' being used, which was a Highland-wide initiative and had been piloted in the older adults service. This linked together relevant health and social care professionals across hospital and community settings to progress discharge plans. We were able to observe the weekly older adult discharge planning meeting involving hospital and community mental health team (CMHT) staff. This was a constructive forum for sharing information focused on the goal of discharge; it was person-centred, and the perspective of family/carers was central and well represented by ward staff.

Use of mental health and incapacity legislation

On the day of our visit seven out of 12 individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). In terms of measures under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), four had a Power of Attorney (PoA) in place and one was awaiting guardianship. Documentation relating to the Mental Health Act and the AWI Act was accessible in individual care records.

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. 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 apart from one instance where an 'as required' medication was not authorised. This was raised with the SCN on the day.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. Seven individuals had s47 certificates in place and it was good to see that these had the required treatment plans attached, other than in one case. We could not find evidence of discussion with welfare proxies in all cases. This was also the case relating to the do not attempt cardio-pulmonary resuscitation (DNACPR) certificates. This was raised with medical staff on the day of the visit.

Recommendation 4:

Medical staff should ensure that welfare proxies are consulted relating to healthcare treatment plans put in place under s47 of the AWI Act and in relation to DNACPR certificates.

For patients who had covert medication in place, all appropriate documentation was in order.

Rights and restrictions

Morlich Ward operated a locked door policy and a notice explained this for visitors. The policy was felt to be commensurate with the level of risk identified, considering that most of the individuals in the ward were subject to detention under the Mental Health Act.

Individuals we met with had a reasonable understanding of their rights and it was good to note that people had written information as well as having had discussions with staff and MHOs. From information gathered, it seemed that the advocacy service was accessible and responsive when needed.

There was one individual who was subject to continuous intervention, and this was appropriately recorded and reviewed.

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. There was one individual who was specified in terms of phone use. This was appropriately recorded and there was a reasoned opinion from the RMO in place.

Activity and occupation

The ward did not have an activity co-ordinator in post and therefore it was mostly the responsibility of nursing staff to provide one-to-one and group activities. This meant that provision of activities could not be prioritised when there was a high level of clinical activity.

The SCN advised that the ward has a good level of input from physiotherapy, with physiotherapy students regularly on placement. It was good to see group exercise being run by the physiotherapy students on the day of the visit, with a small group of four individuals taking part. There was a weekly planner in a prominent place which was fully completed with activities noted for every day of the week.

There was an area in the communal lounge with a table for arts/crafts and games and a reasonable supply of materials; the ward had been given a private donation to buy materials. Our understanding was that there was no source of funding for materials other than private donations and we felt this should be reviewed by hospital managers.

The physical environment

We found the ward environment to be light, clean and fresh smelling. Furniture was in reasonable condition. Individuals had some of their own belongings, giving their rooms a personalised feel and the bedrooms we saw were spacious. All had ensuites with showers fitted only with fixed shower heads. While shower hoses may enable more effective support with personal care, this had been considered and deemed to be a ligature risk and was therefore ruled out.

During our last visit it was noted that the ward did not have a manual or hydraulic hoist in place to enable bathing. We thought this may be necessary for the older adult group at times. The SCN advised that through the use of audit, there had been no instances where the ward has not been able to support an individual with bathing/showering; there was the option of using the hydraulic bath in the neighbouring ward if required. Morlich Ward is due to move to a permanent location in 2026 as part of the New Craigs whole site reconfiguration. Consideration will be given to provision of a hydraulic bath in the permanent ward location.

We did not think the layout of the ward was conducive to allowing staff to observe all activity. We noted that it had been necessary to adapt the environment by ensuring that individuals requiring higher levels of care were placed in bedrooms in the same corridor as the main office.

There was easy access to a pleasant garden space, which had good seating areas and various pots and plants. There were no signs indicating that individuals were smoking in the garden space and discussion with the SCN informed that they do not allow or facilitate this, in line with the relevant legislation. It was good to see that a robust approach was being taken here.

Summary of recommendations

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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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