Mental Welfare Commission for Scotland

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

Date of visit: 17-19 November 2025

Our local visits detail our findings from when 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 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.

About this visit

Section 13 of the Mental Health (Care and Treatment) (Scotland) Act, 2003 describes the visits that the Commission is authorised to undertake. During our visits, we speak to people who use the services, their carers and/or their families, and their advocacy supporters so that we can understand what their experience of care is like.

We aim to identify both good experiences and areas of care, treatment and law which are not respecting the rights of the person being cared for.

We also speak with staff and managers to understand what they are doing to provide the highest quality care, treatment and support according to mental health and incapacity legislation.

When we visit, we use questionnaire prompts and triangulate evidence to check that, for example, good practice is adopted, lessons are learned, and any previous scrutiny recommendations made have been implemented.

We last visited Ward 4 at Dr Gray's Hospital in October 2024 and made 10 recommendations; on our previous visit in 2023, there had also been 10 recommendations made. In 2022, there were two recommendations made.

Previous recommendations covered a range of areas. Over these three visits, the recommendations and comments in the local visit reports highlighted the Commission's ongoing concerns with the audit of person-centred care planning, the lack of psychology in Ward 4, specified persons documentation, the lack of a seven-day activity programme and ongoing concerns about the environment, specifically how it was 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.

In November 2025, we undertook an unannounced, enhanced visit to Ward 4.

Our enhanced visit approach (which we are piloting currently) differs from our usual visit arrangement by extending our presence in a particular setting to more than a single day. We want to receive feedback from families, staff, patients, mental health officers (MHOs) and advocacy workers who cannot always make themselves available to engage with us on a single day or may not feel able to meet us on that day. More than one day in a setting helps to build up familiarity and trust and it also allows us to review more care records.

Where we have identified concerns or made multiple recommendations that have not been met, an enhanced visit helps us to build a more detailed, comprehensive report on the individuals, their families/carers, and the staff team's experiences of delivering care in a specific setting.

Experience of care and treatment

What the Commission did

On this occasion, we visited Ward 4 over a three-day period in November 2025.

Ward 4 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.

There were 17 people receiving care and treatment in Ward 4 throughout our visit. On the first day of our visit, one person was due to be discharged later in the day and as a result of this, we were unable to access their records.

The length of stay ranged from less than one week to four years. At the time of our visit, most people had been in the ward for less than a month, with fewer having been in for up to three months and the remaining people being in for over five months.

Seven people (39%) were receiving care and treatment on a compulsory basis according to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act); there was also someone who was under the provisions of both the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). The other 10 people (55.5%) were in Ward 4 on a voluntary basis.

- Commission staff reviewed all 17 sets of health records of those individuals in the ward.
- We engaged with 15 individuals and four nursing staff who described themselves as key workers/named nurses (some of the other named nurses were on night shift or absent from the ward during our visit).
- We heard from two relatives/carers.
- Seven of the multidisciplinary staff working directly on the unit provided us with information.
- We also received feedback from mental health officers (MHOs) and from the advocacy service who were working with a number of people on the ward at the time of our visit.

What we heard

People receiving care and treatment

What we expect:
As part of the Scottish Government's wider work to improve mental health services and care, core mental health standards, informed by the principles set out in the Mental Health and Wellbeing Strategy, were published in 2023.

Taking account of the standards and mental health and incapacity legislation, we would expect individuals in Ward 4, to receive holistic, person-centred care delivered by an experienced, specialist, multidisciplinary team which is inclusive and recognises the person as a unique individual. We would expect the patient to have a key worker/named nurse with whom they have built or can build a therapeutic and trusting relationship. We would expect the adults receiving care to be fully aware of their rights, to be treated with dignity and respect and for all interventions to be lawful.

What we heard:
There were 17 individuals in the ward when we visited; all 17 (100%) had a confirmed diagnosis of mental illness, with one person having one other diagnosis in addition to a mental illness.

We received feedback from 15 people aged between 22 and 84 years. The average age of those on the ward was 50 years old. 11 (73%) of those in the ward who engaged with us were female and four were male (27%).

The majority of those we spoke with (9 people/60%) told us that they had been given information about the ward. This was more likely where the admission was planned rather than an emergency. We received a copy of the patient and family information leaflet that is available to people who are admitted. There was also a separate carers leaflet that was developed by the Moray Wellbeing Hub which used artwork from someone who was an inpatient in Ward 4.

Again, for most of those in the ward (10 people/67%), we heard that information had been explained in a way that helped their understanding of legal status, how to access advocacy, information about their diagnosis, their medication and any tests or assessments that would be carried out. Three out of the four nurses who spoke with us confirmed that this information was given. Three people however told us that the information had not been given to them in a way that allowed them to understand these aspects of their admission.

We heard from one person who had started getting more information, specifically about the Mental Health Act. This was provided by a translator who was available every day and attended the multidisciplinary (MDT) meeting; they told us that with the use of language line, getting information had been better but that it was more difficult over the weekend.

A few people we spoke to told us that they would like to get accessible and rights-based information about the ward, as they found it difficult to take in a large amount of information, particularly when they were unwell.

Nearly all of the people who engaged with us (13 people/87%) understood that they had a named member of staff to support them while they were in the ward.

Seven out of the 15 (47%) people we spoke with said that they were aware of a plan to make them well so that they can leave the unit. Others explained their desire to be more involved in care decisions, and this was particularly apparent for those who had been in the ward for some time and were waiting for a community placement. They told us:

> "I need a new house, but I don't know what's happening", and
> "I don't know what's happening to find me a care home".

Three of the four nurses we spoke with were not able to confirm that individuals had had opportunity to contribute to their care plans.

We heard comments about the lack of specialist skills in relation to eating disorders and autism spectrum disorder (ASD):

> "There's no focus on anorexia nervosa. Staff tell me they don't know how to manage eating disorders".

There were (13 people/86%) who told us that staff had explained to them why they needed to take medication. We asked people what if they chose to refuse the medication that was prescribed, and nearly all said that they were happy to take what was prescribed:

> "There's medical staff to talk to about medication and they explain and answer any questions".

A few people said to us that they felt they had to take medication. We were told:

> "If I don't take oral medication, then I would get a depot". They said that this had happened to them previously.

We asked if staff talked regularly to people on the ward. Nearly two thirds (10 people/66%) said yes and that staff were "generally good", although we heard that it could "depend on who is in the ward" and a consistent theme was how busy Ward 4 can be. Some people we spoke with mentioned that they were "concerned that others might get overlooked".

Nursing staff told us:

> "One-to-one time with nursing staff is offered daily and they [patients] engage well with this".

We heard from those receiving care and treatment that:

> "There's always someone on shift who listens, but it varies", and
> "They listen but sometimes not in the way I want to be listened to".

Most people (13 people/86%) however, told us that they felt able to ask staff questions about their care and treatment, and that staff answered in a way that they could understand with enough privacy to have a discussion. However, we were advised that this was not possible if someone was in a dormitory:

> "It's horrible – there's no privacy in there".

It was also good to hear that everyone that we spoke to said they could see their relatives, family or carers whenever they wanted to. We heard that there had been some recent difficulties due to a flu outbreak that had restricted visiting, but we were told that this had been managed well by the ward team.

When asked about any limits that had been put in place for people - such as access to their phone, being allowed freely off the ward or other restrictive practices such as people and/or their items being searched - most (12 people/80%) reported that there were no restrictions.

A few individuals told us that there were restrictions to their time off the ward and there was testing in place in relation to the use of substances. We heard that for those individuals, they "felt ok" about the limits that were in place, although they would have preferred there to be more opportunities to have time away from Ward 4.

We asked about different needs that people may have, such as if there was anyone who required support with artificial nutrition via nasogastric tube feeding; or if anyone had experienced restraint or seclusion while in Ward 4. At the time of our visit, the level of observations for all in the ward were at a general level, and there were no continuous interventions required.

There had been one incident of restraint, and this had been recorded through the incident reporting system, DATIX, documented in the care records, and a formal review of care and treatment had taken place to ensure that any future interventions had the lawful safeguards that were required under the Mental Health Act.

We heard from a number of people who were in Ward 4 voluntarily that they understood why the door for accessing and leaving the ward was locked.

A few of the people who were in hospital on a voluntarily basis were aware that they were not to leave the ward; one had agreed to this while another was advised that they needed to see the ward doctor. For a period of three days, the individual's circumstances were not reviewed and they did not leave the ward. We raised this with the service at the time of our visit and were advised that there is a standard operating procedure (SOP) in place that should have been initiated. We were advised that this would be investigated by the service manager.

We wanted to know if anyone in Ward 4 had experienced discrimination during their inpatient stay.

While most that we spoke with (7 people/47%) had no difficulties with communication, a number had (5 people/33%). We heard some comments in relation to these specific needs. Positively, we were told:

> "I have a speech impediment. Staff give me time and support my communication", and
> "I need a translator. Staff manage this well and the translator comes to the ward".

Although we also heard:

> "I have a diagnosis of ASD, but there's a lack of understanding of neurodiversity and communication needs. I need additional time to process, and staff are sometimes not careful with how language is used; this can cause upset to someone with ASD. I feel there is a training issue", and
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> "I have a poor memory caused by my physical illness and need written information. Sometimes what I'm given is hard to understand".

We asked if people felt that they had been treated differently compared to others in the ward. Most (10 people/67%) said no, (2 people/13%) did not answer, and (3 people/20%) said yes. They told us why they felt this way:

> "I have to get my room searched", and
> "My room has no bath. For my physical health needs, it would be good to have this. I also need help to get off the ward and it's not always available".

We also asked if any individuals had been looked after or accommodated by the local authority i.e. care experienced. The majority of those that we spoke with had not (8 people/53%), some preferred not to say (4 people/27%) and there were two people who confirmed that this was their experience (13%).

We wanted to hear about people's experience of the atmosphere on the ward. We asked if it was quiet enough for people to sleep. Most (12 people/80%) said yes; a few (3 people/20%) said no and told us:

> "It depends on who else is in the ward", or
> "If there's snoring in the dorm".

We asked if people felt safe. Nearly everyone we spoke with (12 people/80%) said yes, with (3 people/20%) telling us that they did not feel safe, attributing this to either sharing a bedroom space or to there being no locks on the room doors or in the en-suite bathrooms. We heard:

> "Staff try to manage but it can be really noisy and busy. At times they have to call in extra staff".

The majority of those in the ward at the time of our visit told us that they liked the food (11 people/73%), with a few (4 people/27%) saying that the food was "bland", that food options were "repetitive" and that for some where eating difficulties were a factor, having the calorific value noted next to the meals would have been helpful.

We asked people how well they thought they were looked after overall in Ward 4. We gave people a range of scores to choose from:

- Fantastic: 1 person/7%
- Really good: 5 people/33%
- Okay: 5 people/33%
- Not very good: no one selected this
- Awful: 2 people/13.5%
- Did not wish to answer this question: 2 people/13.5%

Carers/relatives

What we expect:
The Carers (Scotland) Act 2016, implemented in 2018, defines young carers and adult carers and sets out their rights to support, information and inclusion. The Commission's good practice guide titled *Carers, consent and confidentiality* emphasises the importance of carers knowing their rights when navigating health, social work, and social care services.

Our 2025 report 'Not on the radar' highlighted the challenges faced by carers day to day and the importance of carers being recognised as equal partners in care.

We expect therefore that families should always be allowed and encouraged to offer information to professionals involved in a person's care and treatment. In all situations, and regardless of the person's consent or capacity, families can give information to the professionals involved and staff should listen to them. Families and carers often know the person best and can provide valuable information that does not breach the confidentiality of the relationship between the person and the professional team.

What we heard:
The majority of the 15 people we spoke with did not want the Commission to speak with their family or carers, were not in contact with their family or relatives or did not have someone involved in the carer role.

We only heard from two people who were carers to individuals in Ward 4.

Both carers told us that while staff involved them in decisions about the person they cared for, the agreed care plan that set out care and treatment was not discussed or shared with them.

We asked whether the carer was given enough information and had a different response from each – one responded that they did, noting that they were "welcome to attend multidisciplinary team (MDT) meetings", while the other told us that it was only after a Mental Welfare Commission event that they were aware they had a right to attend an MDT. They said that they had never been invited, and when they asked if they could attend, they were told no. They did say that they had attended when their relative was placed on a compulsory treatment order, which had been "useful and informative".

One of the carers said that they had no concerns about their relative, and that the staff knew them well and could gauge when their mental state was affecting their ability to understand what was happening in relation to their stay in hospital. The other carer told us that:

> "The staff were mostly extremely kind and supportive and if I wanted to speak to a nurse, then that was usually possible – I always did this on the phone as there was rarely any private space in the ward".

We asked the carers if they had confidence and trust in the staff. Both carers said that they had. They acknowledged that the longer that the person they cared for was in the ward however, then other issues started to arise. For one carer we heard:

> "My trust and confidence waned and I had to raise a concern in the CTO meeting".

We heard from the carers that there were a range of activities available, and they thought that there was enough to do on the ward. One carer suggested that more strengths-based psychological approaches could have helped with a delayed stay in Ward 4.

Both were aware of the option of a carers assessment and one of the carers had completed their own assessment when "a social worker visited me at home".

Staff working directly on the unit

What we expect:
One of the aims of the core mental health standards (Scottish Government, 2023) is to ensure that a consistent, high-quality service is provided to everyone who needs it. The standards acknowledge that the workforce plays a critical part in how safe, effective, timely, trauma informed, and compassionate based services are delivered.

We therefore expected to find a multidisciplinary approach to the care and treatment of people in Ward 4 underpinned by respect for individual roles and contributions and characterised by positive collaboration between professionals.

What we heard:
The team on Ward 4 comprised of mental health nursing staff, a resident doctor, a medical trainee and the responsible medical officer (RMO).

Specialist input to the ward included a pharmacist, a nurse who was learning disability trained, and the team in Ward 4 could get advice from the community learning disability nurses (CLDNs) and those at Royal Cornhill Hospital (RCH) in Aberdeen. Forensic and eating disorders expertise was also available from RCH. There was also a consultant for older adults who contributed to the team. Referrals for support from other allied health professionals could also be routinely made where required.

Community mental health nurses (CMHNs) from the community mental health team (CMHT), social workers from the mental health team, the access care team, the community care team and mental health officers (MHOs) also attended MDTs where appropriate.

We received an action plan from managers responsible for Ward 4 in October 2024 detailing activity to be progressed to ensure legal authority to treat and audit programmes in place to monitor this. We found that the proposed actions had not been embedded. During this visit, our discussion with the RMO highlighted that there were four patients where treatment required to be authorised and there were errors with three.

We also raised our concerns around the use of judgemental language in one of the care records we reviewed which did not meet professional standards expected. This was addressed with the team at the time of the visit.

Another recommendation the Commission made in October 2024 related to psychology provision. We were told by the service that by August 2025, recruitment to a 0.5WTE clinical psychologist post would be complete. This, however, has not been achieved.

We were pleased to see that having made the recommendation that the ward has regular input from pharmacy after our visit in October 2024, that the action to recruit to a pharmacy post had been delivered. Whilst not a mental health specialist, the pharmacist spoke positively about the team, but, as a generalist, had a “steep learning curve” and with only two days to cover four services there was “not enough of her to go around”.

There was no input from psychology for people admitted to the ward. There was a reflective practice approach in place however, for staff supported by psychology colleagues.

Advocacy

What we expect:
The Mental Health Act is clear about the vital importance of independent advocacy to ensure people’s own voices are heard. People have a legal right to independent advocacy whether they are subject to compulsory measures under the Act or not. This right applies to everyone with a mental illness, personality disorder, learning disability, dementia or related condition, and to all types of independent advocacy.[1]

Section 259 of the Act enshrines this in law. We therefore expect that all patients are offered independent advocacy support.

What we heard:
The advocacy service, Voiceability, is available to people in Ward 4. At the time of our visit, there were eight people receiving input from independent advocacy.

We met with the advocacy worker who runs an advocacy drop-in in the ward on a Tuesday and a Friday from 1pm-3pm. This has been running every week for the last six months or so. It runs jointly with the advocacy worker and the recovery nurse from Ward 4. We heard that the recovery nurse has a strong belief in the advocacy role.

We heard from the advocacy worker that there is sufficient capacity in Voiceability to cover the level of demand coming from the ward. Their focus is supporting those individuals who are detained, but they also have capacity to support individuals who are in the ward on a voluntary basis on a range of issues.

The drop-in session takes place to coincide with the RMO’s ward rounds as these can often generate issues for people and advocacy support is there on hand right away.

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[1] 6. Principles and Standards for Independent Advocacy Reflecting Commissioners' Statutory Responsibility - Independent advocacy: guide for commissioners - gov.scot

The advocacy worker said that there were no significant concerns from their perspective with how the ward provided and delivered on individuals' rights in relation to care and treatment; she told us that nursing staff have a good understanding of the advocacy role and she considers that "overall it is respected and valued".

We were informed that an issue had been raised regarding concerns about poor feedback to referrers; the advocacy worker advised us that she intended to discuss this with the team and address the concerns that had been raised, highlighting where there were potential training issues.

Mental health officers

What we expect:
Mental health officers (MHOs) have statutory powers under the Mental Health Act to support the care and treatment of people whose mental health condition may require the protection afforded by legislation.

As social workers, MHO responsibilities include care planning, assessing mental health needs and whether compulsory intervention may be required, as well as ensuring that the rights and welfare of individuals are protected. It is a critically important role and we would expect active involvement by MHOs in the care of those whose liberty has been impacted by detention in hospital against their wishes.

We would also expect that each person has a current and relevant social circumstances report (SCR) on file which has been sent to the key recipient, the RMO and copied to the Commission (s231 Mental Health Act). The content of an SCR is clearly set out in the Mental Health (Social Circumstances Reports) (Scotland) Regulations 2005 and their purpose in the Code of Practice (Volume 1 Chapter 11). The Commission has published good practice guidance in relation to SCR and also monitors the provision of these statutory reports.

What we heard:
We heard from an MHO advanced practitioner who provided their views and advised us that they were representing other MHOs who were involved in the service provided to Ward 4. We were also able to speak to one of the MHOs working in partnership with one of the people we had met during the visit. Of the 17 individuals in Ward 4, 10 had contact with either a social worker or an MHO. When we looked for SCRs, we found that for seven people, this should have been in their care records. Only three had a completed SCR on file, there was another SCR completed and on record with the Commission but this could not be located on file at the ward and for three individuals, there was no SCR.

We were told that the MHO service takes an individualised approach to supporting people to understand their rights. We heard and noted that MHOs would visit the person regularly while they were on the ward, attend ward rounds when there were specific statutory duties to complete in relation to the Mental Health Act, and support people with the appeal process and named person nominations.

There were said to be particularly good links with the Mental Health Act administrator's office who provided the MHO service with a regular spreadsheet setting out all detained patients to ensure no one is missed in terms of allocation to the MHO service.

One of the MHOs explained that there are concerns regarding the quality of the advocacy service currently being provided by Voiceability. This was said to relate to feedback on referrals and possible training needs being identified. As noted earlier in this report, the advocacy service is aware of this feedback and taking matters forward accordingly.

The MHOs spoke of their important role to consider alternatives to hospital. We heard that in this area of Grampian this is very challenging, that CMHTs are very stretched and it is difficult to identify support services that are able to meet people's holistic needs, especially for individuals with both mental health and physical health/frailty issues.

When talking about Ward 4, one of the MHOs explained that there was a low uptake on advance statements, even though the MHOs promoted these; she was unsure whether the same took place in the ward. We learned that this was not something that the ward promoted, with some ward-based staff believing that this was the realm of advocacy and MHO services; this is despite the Commission's recommendation made regarding advance statements when we visited in 2024.

Both MHOs told us that they believe that the role of the MHO is valued by ward staff and that MHOs are welcome in forums such as ward rounds. We heard them describe working in the ward as a "positive experience" and that communication generally worked well with good sharing of information.

We did hear that there could be more involvement of MHOs at the discharge planning stage and we heard of an example where the MHOs later found out that an individual had been discharged without MHO involvement. The MHO commented that she feels "staff are doing their best working within a broken system".

We were advised that the understanding of the ward/service's duties under the Adult Support and Protection (Scotland) Act, 2007 (ASP Act) was variable but discussions have taken place with the senior charge nurse to promote awareness in the team and explore thresholds.

One of the MHOs highlighted that there were issues with the uncertainty regarding the future of Ward 4, which she does not consider to be helpful for the population of Moray. She explained that there is a lot of anxiety and people are worried that they or their family or their relative will need to go to hospital some distance away.

What else did we hear and learn?

What we expect:
We expect a culture of openness and respect for the Commission’s duty in law to seek and receive a wide range of information, including access to patients’ records. We also expect leaders and managers of services to help facilitate a Commission’s visit and to support their staff during the time the Commission is on and off site.

What we found:
The staff we met and spoke with across the different professional groups provided further information about how the team in Ward 4 works with people, who often have a diverse range of needs, across a broad age range, in a setting that is far from ideal as an adult inpatient mental health unit; feedback from one of the MHOs told us that the ward environment does not support a recovery model.

The following information is what emerged from what we heard, what we observed and what we read in case records.

Key findings

Multidisciplinary team (MDT)

We attended the MDT meeting on one of the days of our visit. We were able to quickly gain the sense that an MDT was a busy morning, with multiple, competing demands; this included the review and detention of a person who had just been admitted, another person who was highly agitated and presenting with challenging behaviour.

We observed professional and knowledgeable staff who adapted their communication style to suit the person’s individual needs.

The meeting itself considered a range of information, including physical and mental health needs, occupational therapy assessments, community activities and social work involvement in discharge planning.

Psychological approaches and recovery work delivered by nursing staff was evident in some people’s care records but was not always reflected in MDT meeting notes.

We noted that there was a duplication with the recording of MDT, as both medical and nursing staff recorded the meeting in separate entries in the electronic files with slightly different information recorded.

There was a prompt sheet that was stored in the electronic system used in Ward 4, TRAKCare, but this was not always used. Had this been used routinely, this would have better supported the review of authority to treat and provided helpful summaries of the discussion that took place, the planned interventions and what actions were required in moving forward.

Activity and education

We wanted to hear about people's access to activities on the ward. As noted previously, those on the ward ranged from aged 22 years to 84 years.

We found very limited information about activities in care records; for the majority, nothing was recorded.

More than half of the individuals we spoke with said they did have access to some activities in Ward 4 (9 people/60%) with the remaining group (6 people/40%) telling us that they did not access activities.

We heard of a range of things to do – decider skills, knitting, colouring, playing the piano, outings with family and staff from Scottish Action for Mental Health (SAMH). We were told that the 'recovery nurse' for the ward had been off for a few weeks, creating a different experience for those who had been admitted more recently. Those individuals who had been in the ward at the time when the recovery nurse was available spoke very positively of their experience.

Whilst we learned of various activities available, there was no evidence that these reflected people's personal choice, preferences or abilities. Neither did we find personalised wellness recovery action plans (WRAP) to support individual approaches to managing mental health.

One of the senior nurses explained that developing a structured activity timetable was in progress, and that currently the ward safety brief, a document that is updated every shift with key information, keeps a record of what ward activities are taking place. We were also told that a member of staff is allocated at the safety brief meeting to help with activities. The recovery nurse, when available, keeps a record of what has been offered and to whom, with a note of whether they accepted or declined to participate.

In 2023 and again in 2024, we repeated a recommendation that managers should ensure an activity programme spanning seven days of the week is offered and to also give consideration to protected supernumerary time for the recovery nurse role. We were pleased to note that the recovery nurse was able to commit mainly to activities, although, in 2026, there is still further work to be done in terms of embedding a programme of meaningful and person-centred activities that are then documented in the person's care records.

We wanted to check whether individuals had access to money to buy the things they needed and it was good to hear that for most, (13 people/77%) they could purchase what they needed. There was only one person who was unable to access their money and this was due to a change in their appointed person who had been delegated for this purpose; the situation was in the process of being resolved at the time of our visit. For the remaining people (3 individuals/18%), there was no information in their records.

Care records and care plans

Electronic care records were stored on TRAKCare, which was easy to navigate, although we were advised that a paper file was kept that contained a limited number of documents. Given that there are risks in running both an electronic and a paper file, in that information kept in one may not be as accurate or up to date as the other, we would advise that moving fully to an electronic system would be safer and more efficient.

The sections on TRAKCare focused on assessment, an admission form, an “asking me” section, physical care aspects that included falls, risk assessments and the Malnutrition Universal Screening Tool (MUST). There were continuation notes/records, historical information, care plans and the MDT notes.

We found that the care records were generally of a good quality, person-centred and trauma informed, although we did find some inconsistencies. In a few care records, we found that some language could be interpreted as pejorative and lacking context. One-to-one contacts between individuals and nursing staff were consistently noted and contained good detail of the person’s mental state, what activity they had engaged in, their interactions and any contact they had had with their family or other professionals.

There was an inconsistent approach to care plans. Some demonstrated a holistic, strengths-based approach to all aspects of care and treatment; they were practical, clear and involved the person. Others were brief, using bullet points rather than a narrative. There was evidence of some people’s involvement in setting goals but not in developing the interventions; these tended to be a list of actions to be taken rather than being personalised. We found that the reviews were brief and did not contain a comprehensive account of how the interventions were supporting the accomplishment of the goals.

We made a recommendation in 2023 and again in 2024 that managers should ensure that there was a regular audit process in place to improve the quality of care plans, and 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.

Although there were some detailed care plans, and we were told that five care plans were being audited each month using the Scottish National Audit Programme (SNAP), there was still variation in the quality and therefore more comprehensive audit and improvement is required.

As part of people's physical healthcare, we asked when the last time individuals were given a full physical health check. This varied with the majority of people receiving this at the time of their admission and then checks were ongoing (9 people/53%); for the others, the records indicated that the checks had been made "recently".

We asked if people had been offered the appropriate screening and/or vaccinations. For most, this was recorded as not applicable (10 people/59%) or individuals had not been offered this (4 people/23%). The information was not recorded in the case records for 3 people (18%).

We asked if any specific health risks had been documented such as those relating to diet, medication, and smoking. More than half of those in the ward had a documented risk (9 people/53%) where actions and interventions were in place. For the other people in Ward 4, there was either no intervention or requirement relating to a physical health risk. The interventions in place included nicotine replacement therapy (NRT) being available, input from the dietician to support weight-related issues, input from the diabetes nurse specialist and involvement from local independent sector organisations who supported people with substance misuse problems.

Discharge care planning was in place for 12 people/70% out of 17 in Ward 4.

Risk assessment
In our previous visit in 2024, we made a recommendation that managers must ensure that all risk assessments were 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. The service committed to undertaking a number of actions in response.

During this visit, we reviewed 16 (94%) of the risk assessments and risk management plans that were in place. Frequency of reviews of risk assessments varied. Nearly half (eight/47%) were noted to be reviewed either daily, weekly or monthly. For the remainder, the frequency of review was not as clear, with this either being noted as "regularly" or "continuous". We found that some were not updated at all. We also noted that for most people, they did not have access to the documentation relating to their assessed risks (11 people/65%).

The most common risk categories related to neglect (six people), risk of self-harm/suicide (five people), risk to others (five people), non-compliance with treatment (five people), risk of substance misuse (four people) and risk of physical problems (four people). For some individuals, multiple risks were recorded.

Risk management plans were mainly task orientated rather than implementing a strength-based approach and consideration was not given in all cases to how risk could be decreased.

There was a lack of MDT input into risk assessment/risk management documentation despite our recommendation of 2024.

During our visit on site, we raised concerns with staff about the risk assessment of those who were deemed to be at risk of self-harm and who had been identified as potentially at risk of using ligatures.

We were aware of two patients who had previously used ligatures. In one case, this had been the cause of admission earlier that week. These individuals had a risk assessment that included an assessment of their suitability to be admitted to Ward 4 rather than transferred to RCH. They, in turn, both had care plans identifying that they were considered to be safe to be cared for in Ward 4. Given that this had been assessed prior to admission, it was unclear how this risk was to be reviewed once on the ward, the time scales in relation to reviewing this, or who would be responsible for the review.

Mental Health Act legislation/authority to treat

The Mental Health Act provides the authority for compulsory treatment of individuals under strict circumstances and describes important safeguards for individuals as to how medical treatment, such as medication, nasogastric tube (NGT) feeding and electroconvulsive treatment (ECT) may be lawfully authorised.

Ensuring appropriate authority to treat has been an issue raised during previous Commission visits to Ward 4 with recommendations made.

Following our review of all 17 care records, we noted that there were seven people who were detained under the Mental Health Act – three with a short-term detention certificate (STDC) and four under a compulsory treatment order (where one individual was also under the AWI Act, with a local authority welfare guardianship order in place).

At the time of this visit, there were no individuals who were receiving ECT or required artificial nutrition via NGT feeding.

We found some errors with the prescribing and documentation relating to the authority to treat.

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. Where applicable, consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health

Act were in place although there were a number of errors that we noted.

One T3 was incorrect in relation to the antipsychotic medication that had been prescribed and with a maximum dose of a benzodiazepine. For another individual, their T2/T3 certificated was due and a second opinion request had only just been completed on that day, thereby creating the potential for treatment out with the Mental Health Act. In the third instance, we could not locate the T3 in the ward folder or on the HePMA system or in the person's file. We were advised that the RMO held this and this was rectified at the time of our visit. For the other concerns, these were raised directly with the RMO.

We noted that for another individual who was in the unit voluntarily, that they were prescribed intramuscular (IM) medication for use as emergency sedation. While the medication was not in use, we made the recommendation to discontinue this at the time of our visit, advising the team that should someone be required to be given IM medication as an emergency, then the correct authority under the Mental Health Act should be used; it may not be likely that, a person at a time of distress, would voluntarily accept IM medication.

We had a discussion with RMO regarding the prescribing of benzodiazepine medications such as lorazepam and diazepam. We were unable to see frequency of dosage and maximum dosage on the HePMA. The RMO advised us that there were no ongoing errors and the pharmacist highlighted that this is an area that they would look at as an ongoing action.

Since our visit in November 2025, we have been told of new audit processes that have been introduced regarding medication and authority to treat based on the Commission's good practice guide. The pharmacist has spoken positively about this and we therefore have not repeated a recommendation this time given the assurance that has been given recently.

Rights and restrictions

The Commission's good practice guidance on specified persons is clear that people who are in hospital should be able to keep contact with friends and family throughout their stay (all of those we spoke with confirmed this to be the case), and should, if appropriate, be able to carry on with their lives in as usual a manner as possible. However, it is possible to use s284 of the Mental Health Act and associated regulations to intervene where restrictions are assessed and deemed as necessary by the responsible medical officer.

There were two people subject to specified persons legislation under s284 at the time of our visit to Ward 4. We found that paperwork relating to those individuals as specified persons was in place but that there was a lack of review. In one case, staff were unaware that the person was no longer specified.

We noted that for one person who was specified for safety and security, they had their bag searched at the front door, in view of other people in the ward and visitors. We raised this with the service at the time of our visit.

Ward 4 has a locked door policy in place (the door was locked at the time of our visit) and the policy was on display at the front door dated 2019. We would advise that the service review and update the policy that is on display, to support when the door is required to be locked.

There is no specific piece of legislation or Scottish guidance dealing with restraint setting out what is lawful in a hospital and what is not. All practice however, should be informed by human rights law, specifically Article 3 (prohibition on torture, inhuman and degrading treatment), Article 8 (respect for autonomy, physical and psychological integrity) and Article 14 (non-discrimination). Where restraint is considered necessary it should be the minimum required to deal with the agreed risk and applied for the minimum possible time. At the time of our visit, there were no individuals who required this restrictive intervention.

Environment

Ward 4 has two three-bedded dormitories and 12 single rooms; with two of the single rooms not having en-suite facilities.

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.

Staff have tried to enhance the ward with some soft furnishings and sensory objects which were in a quiet room in the ward, along with available resources for mindfulness. There is an activity room with gym and art equipment.

The ward was cold in some areas when we visited, and some people complained that they felt cold at night.

The ward environment was run down and tired looking. Staff reported that it can take some time to have repairs completed but felt that this was improving following management meetings with the estates department. We noted windows that could not be opened and several rooms/toilets could not be locked; this was reported to be due to the risk of ligatures. Concerns noted about the ongoing ligature risks in the ward, which we were advised were on the risk register and that a Bolton ligature risk assessment completed.

We have raised our concerns regarding the environment in Ward 4 previously with the chief officer for Moray HSCP and with NHS Grampian. After our last visit in 2024, we made a recommendation that senior managers must attend to the outstanding works in Ward 4 to make the ward a safer environment for individuals and staff and ensure that their health, well-being, privacy and dignity is promoted.

We received the action plan in response to this that stated that the Grampian in patient bed base review is completed and that they would continue to explore options for environmental improvements.

Summary of findings by the Mental Welfare Commission

Areas of good practice

The people that we met on the ward, the two carers and multiprofessional staff in Ward 4 reported positively on the support and teamwork that was in place.

The observed interactions between staff and others at the time of our visit was encouraging and compassionate. Indeed, one person described the staff as ''nightingales'' and felt the cleaning staff deserved special mention. Another described moving from a previous ward to Ward 4 as ''moving from hell to heaven''.

The partnership with Scottish Action for Mental Health (SAMH) to support individuals attend community activities and work with them to become integrated into community activity was a highly valued and effective resource.

We heard from all that we spoke with that they were happy that they had been able to be admitted more locally to Ward 4 and that they would prefer not to go to RCH in Aberdeen. Staying locally allowed people to have contact with their family and to maintain community links, although one person who had been in a rehabilitation ward in Aberdeen did feel the activity and facilities there were superior, feeling most structure and rehabilitation had stopped when they transferred back to Ward 4.

We found that the service made efforts to include people in the decisions around their care and treatment. This extended to invitations to attend MDT meetings and be involved in planning for discharge from hospital.

Wherever possible, care and treatment considered the least restrictive approach and we were pleased to find that no individual was being cared for through continuous intervention, that the majority of individuals were in hospital voluntarily and very few had restrictions in place and where they were, these were reviewed in a timely way. Senior staff explained that "the team are excellent at de-escalation and verbal talkdowns. There is very little use of restraint".

Areas for improvement

There has been a long-standing lack of dedicated psychology input into the unit and there has been little progress in improving this. While we noted that psychology is available to support staff and for outpatients, we would restate our previous recommendation for managers to address this gap.

We recognise that there have been developments with the options for individuals to have access to therapeutic activity and at the time of our visit, the recovery nurse was not available.

However, we continued to find that despite our previous recommendation about delivering a seven-day a week, tailored activity programme this had not progressed to the extent that the range and recording of person-centred activities were taking place.

While we found that risk assessments were in place, the quality and evaluation of these varied.

We would again restate our recommendation 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.

There have been long standing delays in improving the environment of Ward 4 including the ligature reduction work that is urgently required. The Commission has raised this matter over many years. We, however, welcome the confirmation that funding has now been sourced and there is commitment to planned activity to address this significant concern. We also welcome the communication now being shared with the Commission on progress. Whilst this remains an area for improvement, there is assurance that action is now being taken.

Recommendations

As noted throughout this report, a number of recommendations have been made by the Commission previously which remain outstanding at Ward 4. This is a key reason for undertaking an enhanced visit on this occasion.

Whilst some progress is evidenced from the 10 recommendations made in 2023 and the 10 recommendations made in 2024, repetition of the same recommendations is a cause for concern again in 2025, and we will raise this with the senior leaders of the service. The recommendations following this visit are as noted below

Repeated 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 more robust 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. **Previous recommendation to introduce audit met however requires to be more robust to effect change.**

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

Recommendation 4:
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 5:
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 6:
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. **Repeated to ensure actions proposed are indeed progressed.**

New recommendation

Recommendation 7:
It is suggested that the staffing ratio requires to be considered to manage Ward 4. Whilst there was clear evidence of attempts to deliver a recovery focussed approach, the challenge of meeting the variety of needs and outcomes of such a diverse ward population cannot be understated within current resources.

We are very grateful to all those who took the time to engage with us as part of this pilot enhanced visit process undertaken by the Commission. We also thank everyone for their patience given the time that has elapsed between our visit in November 2025 and publication of this report.

We expect NHS Grampian to address the areas of improvement noted in this report and will escalate to senior leaders to ensure this is the case.

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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