Mental Welfare Commission for Scotland

Report on unannounced visit to:
Seafield Hospital, Muirton Ward, 49 Barhill Road, Buckie, AB56 1EJ

Date of visit: 23 April 2026

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

Muirton Ward is an eight-bedded, specialist dementia assessment unit. It is located in the town of Buckie on the Moray coast. Individuals can be admitted directly to the ward or transferred following an initial admission to the mental health unit at Dr Gray's Hospital in Elgin.

On the day of our visit, there were seven people on the ward with one vacant bed. We were told by the staff nurse on duty that there were also two surge beds which were used if the mental health unit at Dr Gray's was at full capacity. She told us there had been a significant reduction in the use of these beds, although on occasions, individuals who had diagnoses of a functional illness, rather than dementia were admitted to them.

We last visited this service in July 2024 on an announced visit and made recommendations around risk assessment, the inclusion of psychology, community staff and an activity therapist in the multidisciplinary team (MDT) and that the service should ensure compliance with the legal authorisation for psychotropic medication. We received an action plan from the service and were satisfied with the response.

On the day of this visit we wanted to follow up on the previous recommendations. In our previous report we had suggested to managers that it might be prudent to consider undertaking an environmental assessment of Muirton Ward to ensure it meets the needs of the people with a diagnosis of dementia. We also wanted to speak with individuals in the ward, any relatives or carers that would meet with us and staff who were available on the day.

We were aware that there had been ongoing discussions with Moray Heath and Social Care Partnership (HSCP) and NHS Grampian in relation to works that were required to be undertaken at Ward 4, Dr Gray's Hospital. There had been a plan considered for Muirton Ward to decant to another area in the main Seafield Hospital. Because of this, improvement works at Muirton Ward had been put on hold. We have continued to receive updates from Moray HSCP and have been told that there are no plans to decant Muirton Ward, as there are further decisions to be made about Ward 4, the mental health unit at Dr Gray's.

Who we met with

We met with four people; we also reviewed their care notes and those of another two individuals and we met with three relatives.

We spoke with ward-based nursing staff, the service manager, the senior charge nurse (SCN), the lead nurse, one of the consultant psychiatrists, the psychologist with responsibility for inpatient mental health services & older adults across Moray,

the occupational therapist (OT) with responsibility across Moray mental health services and the Moray mental health pharmacist.

Commission visitors

Susan Hynes, nursing officer

Susan Tait, nursing officer

What people told us and what we found

We introduced ourselves to six individuals in the ward and where we were able to have a more in-depth discussion with some, the feedback we heard about staffing was positive.

They described the staff as “lovely”, “patient” and described how they were well looked after in the ward. One person told us she was “fed up” waiting for a community placement and would like to be discharged. We wanted to ensure this individual was being supported to ensure their rights were being upheld and there was a discharge plan in place. After reviewing the care records and discussing the matter with staff, we were satisfied they were.

The relatives we spoke to were happy with the care and treatment their relatives received, describing the staff as “kind” and “caring”. All the relatives we spoke to described how they felt listened to and involved in the decisions about their relatives’ care. They were invited to attend part of the MDT meeting and reported finding this very helpful and reassuring.

One relative we spoke to mentioned that their relative’s clothes were kept in a storeroom rather than in the wardrobe in their room, but they had not had an explanation why this had happened. We spoke to staff who agreed to meet to further discuss this matter with the relative. Another relative we met with compared Muirton Ward very favourably to other care settings their relative had been in; they stated they felt the staff were knowledgeable and experienced and told us it was a “Rolls Royce service”.

Relatives told us that when they had raised concerns, these were addressed quickly and in a satisfactory manner. We did hear from some relatives that they felt there was a lack of activities for their family member. They told us the nurses would try to start activities but were often too busy and got called away so could not complete these.

Staff on the ward told us they enjoyed working there and we saw warm interactions between them and individuals receiving care throughout the day. Staff were able to provide us with accurate information about the people in the ward and showed good knowledge about their care, treatment and their legal status. We heard the ward had one vacancy, but this had been recruited to.

Care, treatment, support, and participation

Nursing staff told us that some documentation had been transferred to the electronic system TRAKCare since our last visit.

We accessed individual electronic records on the day of the visit as well as paper records that were still in place. We were told the plan was for the ward to have all

recording and documents transferred to the electronic system; to be able to view all documentation recorded electronically in one place will be helpful.

We were told that the ward-based staff and the consultant psychiatrists recorded all contact with individuals on the electronic system. The weekly MDT meetings were also recorded on TRAKCare, along with care plans, some nursing assessments, risk assessments, risk management plans and 'ASSKINGME' assessment which supports the identification of falls risk, mobility requirements, cognitive issues and nutritional requirements.

We found most other physical health assessments, legal paperwork, and 'getting to know me' booklets in the paper records, as well as paper copies of care plans. We saw regular assessment of the side effects of pain and medication as it was recognised that individuals in Muirton Ward may not be able to communicate these issues. We saw evidence of these assessments being reviewed in the MDT meetings.

Where individuals had been open to mental health services prior to admission, there was detailed information in Situation, Background, Assessment, Recommendation (SBAR) format which provided staff with background and historical information about the person, their circumstances and support prior to admission.

Since we last visited the service, care plans have moved to an electronic format. We found person-centred care plans and although brief, most contained appropriate levels of information; some were more task orientated rather than focussing on how the intervention should be delivered. The care plans we reviewed incorporated information from 'getting to know me' booklets and from relatives and carers. This allowed personalised and targeted interventions particularly relating to non-pharmacological interventions for stress and distressed behaviour.

We were aware during our previous visit there had been discussion with the staff about the importance of reviewing care plans and updating them following review, as in some, it appeared that the care plan still related to the assessment stage, despite a review having taken place.

When we reviewed the care plans on this visit, we found that reviews were being undertaken regularly however, some lacked detail. We found examples where an individual had been admitted several months earlier, had undergone an assessment, but it was recorded in the review 'no change' or 'remains the same'. We would hope to see the assessment findings reflected in the care plan and the development of the care and treatment.

It was unclear if the person's care plans had been shared with their relative or legal proxy or if they or their relative were involved in developing such plans as there was no recording of this in the file.

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.

Recommendation 1:
Managers should ensure that care plan reviews are detailed and provide a summative evaluation of the efficacy of care interventions.

We found all individuals had a comprehensive risk assessment and risk management plan. The Grampian electronic risk assessment tool was used and contained a good level of detail with a corresponding management plan for identified risks and appropriate mitigation plans. We found these were updated regularly.

We found completed 'do not attempt cardiopulmonary resuscitation' (DNACPR) certificates in the paper records. Where an adult cannot give consent and has a welfare guardian or attorney with the relevant powers in place, the guardian or attorney must be made aware of any advance decision to give, or to not give, CPR.

Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking whatever steps are possible to establish the wishes of the individual. From the files that we reviewed, we found that DNACPR forms had clearly recorded where proxy decision makers and families had been consulted appropriately, although in one case this had not been updated when the form was updated, which was raised with the service on the day.

Multidisciplinary team (MDT)
There continued to be two consultant psychiatrists that covered the ward, and we were told that MDT meetings took place weekly.

We were told that individuals in the ward continued to access allied health professional (AHPs) and psychological services via a referral system. There was community mental health team and pharmacy involvement in the MDT team meeting.

We noted that there were several individuals in the ward who would have benefitted from psychology input due to their complex presentations. Psychology input is a crucial part of an individual's care and treatment, and we found that no one in the ward had a psychological formulation to support the management of stressed/distressed behaviours. We note that a recommendation had been made at our previous visit asking the service to ensure access was made available for

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

dedicated psychology input and had been told plans were in place to ensure psychology attended the MDT meetings to support a psychological approach.

We were told by staff this had been difficult to establish; there was currently a Grampian wide review of psychology services and there was limited capacity to support psychology input into Muirton Ward. This was disappointing, especially as we had seen in other dementia assessment wards in Grampian how helpful this input had been and had hoped to see this input in Muirton Ward. We heard there was scoping work being undertaken to agree the psychological training and support requirements for all staff working in dementia settings, though there is no timeline for this.

Recommendation 2:
Managers must ensure that the unit has dedicated psychology input to inform care and treatment and aid individuals' recovery and rehabilitation.

We were also told of the limited capacity for OT with one therapist covering all inpatient and older adult community mental health services in Moray. The focus of their work needs to be on assessments that would inform the MDT about the person's occupational strengths, areas of needs and to support discharge planning. The OT did not have capacity to support ongoing occupation / activity planning on the ward, although an assessment of activity level and activity preferences had been introduced to encourage all staff's awareness of activity need and the recognition and recording of activity undertaken.

We found there was an excellent review of individuals physical health needs with the link between physical and mental health care recorded in the individual's records, along with regular physical healthcare monitoring.

The weekly MDT meeting documents that we reviewed recorded who was present at the meeting, along with everyone's updates/progress and recorded the actions/outcomes from the meeting. Families were invited to attend the meeting and people we spoke to described good communication with the team.

We saw evidence that when families could not attend, nursing staff updated them of the outcomes from the meeting. We saw the consultant psychiatrists regularly reviewed individual's care and treatment, including their detention status and this was recorded in the MDT record.

We were told that there continued to be weekly contact with social work to discuss and receive updates on the progress of discharge planning and we found evidence of this in the care records. We reviewed one person whose discharge was delayed and were told about significant delays with the local authority being able to progress the application for a welfare guardianship order. We had been made aware of this in

other cases and will write to the HSCP to be updated about the actions it is taking in relation to this issue. This person was the only one whose discharge was delayed.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We reviewed the legal documentation available in the records and found that all Mental Health Act paperwork was in order.

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 had been completed, although one was not available on the ward, and was this requested from medical records. This was concerning, as nursing staff should check legal authority is in place prior to dispensing and administering medication.

One person's medication had recently been changed and was not legally authorised by the current T3. This was discussed with the RMO on the day with appropriate actions taken. However, we are repeating our previous recommendation regarding the need to ensure all psychotropic medication is legally authorised.

Recommendation 3:
Managers, medical and nursing staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular auditing compliance with this should be put in place.

The mental health pharmacist for Moray had regular contact with Muirton Ward and was undertaking quality improvement work across Moray to ensure 'as required' medication is prescribed in line with legal requirements and recorded according to policy and best practice. We look forward to seeing the progress of this work in future visits to mental health wards in Moray.

Five individuals were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). For individuals who had an appointed legal proxy in place under the AWI Act, we saw a copy of the legal order in place, such as power of attorney or welfare guardianship orders.

The ward had a display board in the staff office that provided an overview of all individuals in the ward and this recorded their legal status under the Mental Health Act. Previously, we had noted that this board clearly recorded the specific section of the AWI Act on the board, however, this was not recorded on this visit. We discussed with the SCN that this had been viewed as good practice previously and that it would be positive to see it reinstated.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan 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, who has relevant powers and record this on the form. We found that all s47 certificates were completed in accordance with the AWI Act code of practice for medical practitioners and had appropriate treatment plans.

Where covert medication pathways were in place, we saw appropriate documentation, including detailed reasons for the need to use this, along with appropriate review and administration plans. The Commission has produced good practice guidance on the use of covert medication.[2]

Rights and restrictions

The ward had a locked door policy in place that was commensurate with the level of risk identified with this group of people. The ward continued to have good links with VoiceAbility, the local advocacy service, who regularly visited, supporting individuals with their rights.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. No one was subject to specified person legislation on the day of this visit.

When we are reviewing individual files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any advance statements, but this was due to the advanced stages of illness for most of the individuals on the ward.

The Commission has developed *Rights in Mind.*[3] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment. We saw information about this pathway in the ward and in the relatives' information pack.

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We wanted to follow up on our recommendation about activities that we have made on our previous two visits.

On our previous visit, we had found more evidence of activities taking place and the health care support worker (HCSW) recorded these separately in an activity folder. The ward had a new activity board that identified which activities were happening on each day. We were disappointed to find this progress had not been maintained, the activity folder was not being completed, and on the day of our visit the new activity board was blank.

We heard from staff about their attempts to organise activities, but this could be difficult due to clinical activity on the ward and lack of staff capacity to complete these activities. Relatives we spoke to also reported a lack of activity in the ward, though there were materials in the ward if they wanted to engage their relative in a craft activity.

Therapeutic activity is an important factor in supporting the management of stressed and distressed behaviour and we are concerned to see the lack of progress in the provision of activity. We were told by the service manager and SCN that following a recent staffing review an additional three registered nurses and one healthcare support worker were being allocated to the staffing establishment for Muirton Ward.

We were told that these additional staff will allow members of the team to be released to support activity provision in the ward. Given that we have raised concerns about the lack of activity provision in our previous two visits, we are therefore repeating our recommendation but would hope the increased staffing has the anticipated positive effect on activity provision.

Recommendation 4:
Managers must ensure there is appropriate therapeutic activity provision for individuals in the ward.

The physical environment

Muirton is an older-style ward that is spacious, with a corridor that leads to five single rooms and two two-bedded dormitories. Each dormitory has access to a shower room and toilet.

The ward has a dining/lounge area, with access through to a large conservatory. There is a television displayed on the wall in the lounge. There is ample sitting areas and another quiet lounge, where visitors could meet with their relatives in privacy.

There is space for individuals to walk freely up the large corridor area. The ward has an enclosed, well-tended garden area that individuals and relatives have access to, particularly on days when the weather was good.

The ward was warm and welcoming; people we spoke to on the day highlighted the good level of cleanliness on the ward and the hard work of the domestic staff. We saw information about the Mental Welfare Commission and local carers support groups on display.

We saw some dementia friendly signage displayed throughout the ward, however we felt this could be more prominent and it might be helpful for the service to undertake an environmental assessment. This would ensure the ward meets the needs of people with dementia in the best way possible and supports individuals finding their way around the ward.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plan reviews are detailed and provide a summative evaluation of the efficacy of care interventions.

Recommendation 2:
Managers must ensure that the unit has dedicated psychology input to inform care and treatment and aid individuals' recovery and rehabilitation.

Recommendation 3:
Managers, medical and nursing staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular auditing compliance with this should be put in place.

Recommendation 4:
Managers must ensure there is appropriate therapeutic activity provision for individuals in the ward.

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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