Mental Welfare Commission for Scotland

Report on announced visit to: Brodie Ward, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH

Date of visit: 14 September 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and we are presently undertaking a variety of face to face and/or virtual visits. This local visit was able to be carried out face-to-face.

Brodie Ward is an inpatient ward for males and females who have an acquired brain injury or neurological disorder with severe psychological and behavioural symptoms. The ward moved to its current location from Dunnotar Ward approximately two years ago. This was due to the ongoing renovation and anti-ligature works being undertaken across the Royal Cornhill site.

The senior charge nurse (SCN) told us that the ward can take up to 10 patients. However, during the Covd-19 pandemic this was reduced to eight, in order to adhere to social distancing measures and due to staffing pressures.

The ward has a mixture of single rooms and dormitory accommodation and has been arranged so that each patient has a room to themselves.

We last visited this service on 19 June 2019 and made recommendations relating to care planning. On the day of this visit we wanted to meet with patients and/or relatives/carers and follow up on the previous recommendation.

Who we met with

We reviewed the care and treatment of six patients and met with two relatives.

We spoke with the SCN, ward staff and consultant psychiatrist. Contact was also made the advocacy service.

Commission visitors

Tracey Ferguson, Social Work Officer

Anne Buchanan, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Patients we met with were complimentary of staff support as were relatives. We observed positive interactions between staff and patients during the time we spent on the ward and the ward had a sense of calmness on the day we visited.

We were told that many of the patients on the ward have been in hospital for a considerable period of time and present with very complex physical and mental health needs, as well as limited verbal communication. Staff told us that due to the nature of some patients' illness their involvement in social, recreational and therapeutic activities can at times be limited.

We spoke to staff throughout the day and were able to see that the staff team knew the patients extremely well. There was a sense of commitment and experience within the staff group that shone through when speaking with the staff. Staff told us about the additional pressures and challenges that the Covid-19 pandemic has brought, such as trying to support the patients to adhere to social distancing measures, visiting restrictions, along with not being able to take patients out and about in the community due to lockdown measures. Relatives we spoke with also told us about the difficulties of restricted visiting and the impact that they felt this had on their loved ones. We were pleased to hear that visiting has recommenced in the ward and patients were spending more time outdoors in the community.

Managers told us that the service has appointed a new consultant psychiatrist to the ward, and how this permanent addition to the team has been very welcomed and positive. We also heard that the ward continues to have regular input from the GP to assist with physical health matters and they are very much part of the weekly multidisciplinary team (MDT) meetings. We viewed minutes of MDT meetings and were able to see who attended these meetings, along with discussion and outcome of the meetings. We were told that patients also have an annual review meeting (or sooner if required) with all involved professionals, and relatives. The ward has regular input from psychology and occupational therapy, both in group work and on an individual basis and regular input from pharmacy which we were able to see in individual files.

During file reviews, we saw evidence of detailed mental health assessments along with risk assessments and risk management plans that were reviewed regularly throughout the patient's journey. We saw some detailed 'getting to know you' forms in patients files which gave a good account of the patient's history. Good attention was given to patient's physical health care needs along with assessment and provision provided by dietetic, speech and language therapy (SALT), physiotherapy when required.

We wanted to follow up in relation to our recommendation from our last visit regarding care plans. We saw evidence of detailed care plans that covered patients' physical and mental health care needs. We saw regular reviews were taking place, along with evaluation of the overall care plan. There was clear recordings in notes where patients had received one-to-one sessions with nursing staff. Where it was recorded that patients were unable to sign their care plans and have a proxy decision maker in place, we advised that it would be good practice for

these to be shared and/or signed by the proxy. This will evidence that they had been involved and contributed to the care plans.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Use of mental health and incapacity legislation

All patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

We reviewed records for six of those patients and were pleased to see that the Mental Health Act paperwork within records was well-maintained and was easy to access within files.

Paperwork relating to treatment under part 16 of the Mental Health Act was in good order, with relevant forms authorising medication being prescribed.

Part 16 (s235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under Mental Health Act were in place for five of the patients. We had further discussion with the consultant psychiatrist regarding a T2 certificate that was in place for one of the patients and advised that the patient's consent should continue to be reviewed. We found a discrepancy in the same T2, in that the patient was prescribed intra-muscular (IM) medication. Our view is that a patient is very unlikely to be consenting to IM medication at the time this is felt to be urgently necessary. We followed this up on the day with the consultant psychiatrist.

Where patients had been assessed as requiring medication covertly, we saw detailed covert pathways in place along with reviews of these.

Adults with Incapacity (Scotland) 2000 Act (the 'AWI Act') section 47 consent to treatment certificates were in order along with accompanying treatment plans. 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 AWI Act.

Where a patient had an appointed legal proxy under the AWI Act, we saw copies of orders within the patient files apart from one, which we followed up with the SCN on the day.

Rights and restrictions

Where appropriate, supported decision-making was being promoted and encouraged within the ward. The ward had good connections with advocacy services and we were able to see this from patient files. Advocacy services involved in supporting the patient in mental health tribunals and/or during review meetings.

We spoke with advocacy as part of the visit who told us that they feel welcome on the ward and have been involved and supported many of the patients for some time, given that all patients were subject to the Mental Health Act.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We were told that at the beginning of the pandemic, the occupational therapist (OT) who provided input to the ward, was relocated. Activities were limited and due to the Covid-19 restrictions in place this was a challenge for staff, particularly during lockdown periods.

The OT has recently been relocated back to the service and we were able to view the activity planner displayed on the wall in the ward. The ward also has an activities co-ordinator two and a half days per week and we were able to see recordings of activities in patients' notes. We felt that the recordings could have been more outcome focussed, as opposed to only recording the description of the activity. We had a further discussion with the SCN on the day regarding this issue. The ward also has access to a vehicle to take patients out and about in the community, which staff and patients told us they enjoyed.

The physical environment

The ward compromises of six single en-suite rooms and two dormitories, one for each patient. The SCN told us that some adaptions have been made since moving into the ward given the physical needs of patients. There is a dining area where patients can have their meals with access to an enclosed garden area. Soft furnishings have recently been purchased and we were told about other plans for the ward environment and garden area so patients can benefit from the space. We saw patients room that were personalised, with pictures on the walls, along with televisions in their rooms.

Service response to recommendations

The Commission made no recommendations, therefore no response is required.

SUZANNE MCGUINNESS
Executive Director (Social Work)

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 MWC 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 individual care, treatment and support is 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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