Mental Welfare Commission for Scotland

Report on announced visit to: Huntly, Fraser and Dunnotar Wards, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH

Date of visit: 21 September 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). 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.

We visited the adult acute mental health admission wards Huntly, Fraser and Dunnotar in Royal Cornhill Hospital. The three wards receive admissions on a geographical basis covering Aberdeen city and Aberdeenshire, along with admissions from the islands of Orkney and Shetland. Although the wards try to admit patients assigned to their geographical area, this does not always happen due to capacity, therefore patients may have to be admitted to another ward, then transferred when a bed becomes available.

Each ward has 21 beds and are all mixed-sex wards with a mixture of single rooms and dormitory accommodation. On the day of our visit, all three wards were at near or full capacity. We were able to see on this visit that all wards have now undergone extensive refurbishment as part of the ligature programme works.

We were told that there have been significant staffing challenges, along with bed pressures across the service since the pandemic and this continues to be an issue. Managers have a daily huddle to discuss bed pressures and staffing issues, and we heard that there continues to be a recruitment drive to fill vacant posts.

We last visited this service on 11 June 2019 and made recommendations relating to care planning, recording activities, psychology provision and environment. For this visit we wanted to meet with patients and relatives or carers and follow up on the previous recommendations.

Who we met with

We reviewed the care and treatment of 20 patients and spoke with seven relatives.

We spoke with the senior charge nurses (SCNs), depute charge nurses, ward doctors and other ward staff. Contact was also made the advocacy service.

Commission visitors

Tracey Ferguson, Social Work Officer

Anne Buchanan, Nursing Officer

Lesley Paterson, Nursing Officer

Graham Morgan, Participation and Engagement officer

Alyson Paterson, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit, some patients had recently been admitted to the wards and were acutely unwell, whilst some patients were working towards discharge, as their mental health had improved. Nursing staff told us that since the pandemic, they had noted that there has been an increase in patients being admitted with increased levels of acute mental health symptoms than prior to this pandemic, with patient's recovery taking longer. Staff had also recognised that some patients were being re-admitted back to the ward, shortly after discharge had taken place.

Patient feedback to us was variable. Some told us that they felt safe in the wards and reported that staff were kind, approachable and compassionate. We heard that for some, they found that staff were supportive and readily available to talk to, reporting that the atmosphere in the ward was calm and relaxed. Other patients told us that it can be noisy in the wards, staff were busy, and that there was a lack of privacy when having to share a dormitory. Whilst some patients were able to tell us about their care and treatment and that they felt involved in their care, this was not the case for all that we spoke to. Some patients told us that they rarely saw the doctor, they found communication to be poor, they felt bored on the ward, and found no benefit from being in hospital.

Feedback from relatives was mainly positive about their relative's stay on the ward. Relatives told us that staff had really supported the contact with family and felt involved in their care. Where relatives raised specific case issues with practitioners, these were followed up on with the SCNs.

Care planning and documentation

We wanted to follow up the recommendation from our last visit regarding care plans. We saw some evidence of detailed care plans, however this was not consistent across the three wards. The recordings in some care plans were more generic; for example, 'monitor mental state'. Although care plans were reviewed regularly, it was difficult to know how progress was being monitored between each review as there was little evidence of evaluation. Not all care plans were holistic in covering patients physical and mental health needs. Furthermore, patient participation in care planning was not clearly documented in the files we reviewed. However, the continuous intervention care plans were detailed with clear rationale for the use of continuous intervention with clear goals.

Staff told us about their continued frustration around the ability to record information in the Grampian admission booklet, specifically in relation to the limited space provided in this document that is available for care planning. Given that this was a recommendation from our last visit and staff advised us of this issue, we wanted to find out what action NHS Grampian has taken following on from the action plan that was sent to the Commission as to how this recommendation was going to be met.

We were told that due to the pandemic, the short life working group that was in the process of being set up to review documentation had to be put on hold. Managers gave a commitment to starting up this group, as this is required in order to review the current documentation before planning what the next steps will be. The audit tool and audit process will also be part of this review, and the Commission will write to managers separately requesting an update.

In reviewing the patient files, we saw evidence of detailed assessments for mental health along with risk assessments and risk management plans at the point of admission. We found where patients had psychology input to their care and treatment and formulation plans. We were told that the wards do not have dedicated psychology but continue to operate a referral system.

The wards have weekly multidisciplinary team (MDT) meetings and we viewed MDT records and saw recorded actions and outcomes. We were unsure about patient participation during these and were told that these are professional meetings. It was unclear who fed back to the patient and we had a discussion on the day with the SCNs that it should be clearly documented in the MDT record. Some patients told us that they meet regularly with the doctor or nurse separately to discuss their care and treatment; others told us that it has been a while since they saw a doctor.

In the notes there was evidence of one-to-one meetings with nursing staff, along with engagement with allied health professionals (AHPs), medical reviews and recreational activities. We saw input from occupational therapy (OT) that included functional assessments, group work and input from physiotherapy where appropriate.

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

The wards all have clinical cover provided by a psychiatrist however we were told that there has been ongoing difficulty recruiting consultant psychiatrists and that locum doctors are having to provide input to some of the wards. Some patients were unhappy with the turnover of locum doctors meaning they saw a number of different doctors during their stay.

Use of mental health and incapacity legislation

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were not all in place for patients and not all treatments being administered were authorised.

In adult acute admission wards, administration of 'as required' intra-muscular (IM) psychotropic medication almost always requires the legislative authority of the Mental Health Act. We found T2 forms including as required medication to be administered intra-muscularly

for agitation. Our view is that a patient is very unlikely to be consenting to IM medication for agitation at the time this is felt to be urgently necessary. We followed this up on the day with the SCNs, managers and clinicians, and will follow this up to ensure patients are aware of their rights in relation to their treatment.

We were told that pharmacy carries out an annual audit of T2/T3 forms, however given the concerns raised from this visit regarding patient's treatment, our view is that an annual review is insufficient.

Recommendation 1:

Individual treatment should be discussed as part of the weekly MDT meeting ensuring the appropriate treatments are authorised under the Mental Health Act for patients.

Rights and restrictions

We were advised that patients are asked to sign a ward contract on admission to Dunnotar ward and we were told that this document continues to be discussed throughout the patient's admission. We felt that the wording in this document around room and individual searches needs to be clearer, particularly around the patients consent and rights in relation to this.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied.

When the responsible medical officer (RMO) has determined that room searches are required for this purpose, they should make the patient a specified person for safety and security in hospitals under s286 of the Mental Health Act. This is necessary to provide legislative authority for this restriction. It also provides the appropriate framework for review of the restrictions and the patient with their right to appeal against these.

Where patients had been made specified persons, we found evidence of the documentation however in one case we found no reasoned opinion in the care plan and brought this to SCN attention on the day.

Our specified persons good practice guidance is available on our website at: http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

We spoke with advocacy as part of the visit. They told us that they feel welcome on the ward and continue to be involved and support many of the patients. Advocacy told us that they are not as visible on the ward as they were before the pandemic, however continue to receive referrals and make contact with patients either via phone or face-to-face.

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

Patients were able to tell us about activities that were happening on and off of the ward. We heard from the patient about the activities that they are involved in with OT, such as cooking groups, going to the gym, arts and crafts; others told us that they enjoyed a walk in the grounds. We heard from some patients there was not enough to do on the wards.

OT activities were displayed on the walls of the wards and we heard that since pandemic, OT staff are providing activities on the ward as opposed to using the recovery resource centre for all activities. Staff and patients told us that this is working well. We were told that some activities have been restricted due to social distancing measures such the gym, with a booking system that has now been introduced.

In Huntly Ward, we heard that on a monthly basis staff and patients choose a "topic of the month"; the most recent topic was on "sleep hygiene". Staff were supporting the patients to better understand how to achieve a good night's sleep, what things to avoid that could interrupt sleep, and what methods and strategies can help promote a sleep pattern that aids recovery. Patients and staff talked positively about this.

The physical environment

The ward compromises of single en-suite rooms and dormitories. We were told that the single bedrooms are largely for individuals who are acutely unwell, who require continuous intervention or are unable to cope with sleeping in a shared bedroom. Some patients told us that they found it difficult to share a dormitory due to a lack of privacy.

The environments were bright, clean and we were able to see the recent renovations that have taken place across all wards, including the completed ligature reduction works. Each ward has a dining area and separate TV area.

Some patients were unhappy about the lack of outdoor space, particularly where there were restrictions in place. Each ward had access to an outdoor patio area however this is not enclosed and would not provide a safe and secure environment for all patients who are acutely unwell.

Any other comments

On the day of the visit, medical staff raised their concerns around the current Covid-19 restrictions in place across all wards in Royal Cornhill Hospital. They advised us that they felt guidance is overly restrictive and not compatible with the Mental Health Act, nor with the principles of the human rights act. We heard how patients were being made to isolate for significantly longer periods than noted in the national guidelines and that this is having a detrimental impact on patients, their mental state, their quality of life and their discharge planning. We discussed this with managers on the day of the visit as no patients raised this as an issue with us. We were told that this related to a specific situation. We discussed this with managers on the day and they told us that advice had been taken from Infection control. By the time of our visit, the situation had changed however we reminded managers that no unnecessary restrictions should be placed on patients where there is no authority in place. We

also advised managers that NHS Grampian guidelines needs to be compatible with those issued by Scottish Government.

We were pleased to hear of a 'psychological resilience hub' that has been developed since the pandemic, and that has provided support for all staff and continues to be part of the ongoing provision for the clinical teams. We heard about Project Wing Man which is a 'safe place' for staff to talk about their concerns and receive peer support. We were also told of another initiative called "you care cause we care" which has helped staff with families especially during the early days and weeks of the pandemic, when staff were anxious about taking Covid home to their families and the potential risks.

Summary of Recommendations

1. Individual treatment should be discussed as part of the weekly MDT meeting ensuring the appropriate treatments are authorised under Mental Health Act for patients.

Service response to recommendations

The Commission requires a response to this recommendation within three months of receiving this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

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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