Mental Welfare Commission for Scotland

Report on announced visit to: Royal Cornhill Hospital, Strathbeg and Loirston Wards, Cornhill Road, Aberdeen AB25 2XH

Date of visit: 28 April 2022

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 where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

The learning disability service consist of two wards, Strathbeg and Loirston. Strathbeg Ward is for adults with a learning disability who present with behaviour that can be harmful to themselves or others, requiring close supervision in a secure environment. At the time of our visit, the ward had seven patients.

Loirston Ward is an admission ward which provides assessment and treatment for adults with a learning disability who have a psychiatric illness or present with behaviour which can be complex to manage. At the time of our visit, the ward had five patients. Managers told us that between the two wards, the current capacity is capped at a maximum of 13 patients.

We last carried out a virtual visit to this service on 15 and 16 March 2021 and made recommendations in relation to activities and the seclusion policy.

On the day of this visit we wanted to follow up on the previous recommendations and speak with patients, relatives and staff. We had also heard that since the wards have moved from Elmwood Hospital, both ward environments are not designed specifically for people with a learning disability, who may also have complex sensory needs. We had heard that a functionality assessment of both wards had been completed and we wanted to get an update of this and to see the current environment.

Who we met with

Prior to the visit we met with the clinical nurse manager, inpatient service manager and senior charge nurses (SCN) of both wards, via video call. A telephone call with the consultant psychiatrist also took place prior to the visit. On the day of the visit we spoke with a range of nursing/ward staff and managers. We also met with the occupational therapist (OT) and liaised with the local advocacy service.

We spoke with and reviewed the care and treatment of seven patients and spoke to a relative.

Commission visitors

Tracey Ferguson, social work officer

Gillian Gibson, nursing officer

Alyson Paterson, social work officer

What people told us and what we found

Care, treatment, support and participation

Feedback from the patients and relative was positive about the staff on the wards and those that we spoke with were generally happy with their level of care. Some patients told us that communication was good, as did the relative, and others told us how they meet with their consultant regularly and attend meetings. Some patients were able to tell us about their care and treatment and discharge planning. For others, we were unable to have such detailed conversations due to the level of their disability, however we were able to observe patients throughout the day, interacting with staff in a positive manner. Some patients told us that they were fed up of still being in hospital.

Speaking to the staff team throughout the day, we noted that staff knew their patients well. Where a patient required support or became distressed, we observed staff responding to the patient quickly.

We heard that there is good support from advocacy to the wards and that patients have regular contact with their advocate, and are supported in meetings/tribunals.

Staffing challenges were acknowledged by managers who are continuing to be proactive in their efforts to recruit to posts. We recognise that this is an issue nationally, and specifically with learning disability nurses.

A few of the patients we spoke to felt that at times, bank/agency staff were unfamiliar with their care and treatment plans which had an impact on their ability to deliver the quality of care they wanted. We heard that where possible, the wards use regular bank staff to promote consistency and relationship building, which enhances the quality of care provided.

Nursing care plans

On reviewing patient notes we found detailed nursing assessments for those who had been admitted recently; for patients who had been in hospital for some time, we found that there was regular updates of nursing assessments. Detailed risk assessments and risk management plans were in place, with most of them being reviewed regularly. However, review dates were not recorded in some files. We brought this to the SCNs' and managers' attention on the day.

There were detailed, person-centred, holistic care plans in place that were being reviewed regularly with recorded evaluation. In some patient records there was detailed information that was covered in multiple care plans. We found that some of this information was repetitive and could be condensed in the care plan. We discussed this further with the lead nurse who informed us that there is a plan for a review of the paperwork in files. This would ensure that the most up-to-date information in the file is relevant to support the patient. We were aware that some patients have been in hospital for an extended period of time, and were pleased to hear that this review is taking place.

Staff continue to carry out patients annual health checks on the ward and we saw clear evidence of physical health care and monitoring.

We heard that some staff have had training in positive behavioural support (PBS), provided by their own psychology colleagues and this training will continue to be delivered to the ward staff.

Multidisciplinary team (MDT)

The wards have comprehensive input from a multi-disciplinary team (MDT) into patients care and treatment, working effectively in addressing patients holistic needs.

From reviewing the patient files we saw that MDT meetings take place every week and we saw recorded minutes of these meetings, with noted actions and outcomes. All patients in Strathbeg Ward continue to be managed using the care programme approach (CPA). This provides a robust framework for managing patient care, particularly in relation to the management of risk. Patients did not always attend the weekly meeting but did have an opportunity to contribute; the consultant psychiatrist told us that he meets with patients before and after meetings. Most meetings are continuing to happen via video link, and we were told that patients/welfare guardians/advocacy also have option to attend, where appropriate.

We were told that there are currently five patients in Strathbeg Ward where there have been delays in their discharge from hospital. Following on from our last visit, we have continued to review the discharge plans for two patients, who have been in hospital for an extended period of time and where there has been no progress regarding this. We were advised that the lack of progress has been caused by there being no available accommodation in the community. We were pleased to hear that some progress has now been made for both of these patients and for a further three patients. We will continue to follow up on these individual cases with the responsible medical officer (RMO) and with the health and social care partnership (HSCP).

Nursing staff and the RMO told us about some patients on Loirston Ward that are ready for discharge back to the community. We heard about the plans that are in place to progress with their discharge planning.

We found a detailed, person-centred approach in patients files used in OT and psychology assessments/ formulations. There was regular input from speech and language therapy (SALT) that provided continued use of effective communication strategies to engage patients and promote participation. This included easy read version of documents such as pictorial activity planners.

Use of mental health and incapacity legislation

On the day of our visit, eight patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') across the two wards. Ward staff and advocacy continue to support patients with their rights and we saw evidence of this in patient files, where information was accessible and in pictorial format. Some patients we spoke with had a good understanding of their rights; the ward has a Mental Health Act checklist in the patient's file.

Of those patients that were subject to compulsory treatment, we reviewed the legal documentation available in their files and found that all Mental Health Act paperwork was in order.

Paperwork relating to treatment under part 16 (s235-248) of the Mental Health Act was in order. The authorising treatment forms (T3) completed by the responsible medical officer that record non-consent, were available, apart from one. We brought this to the attention of the SCN on the day and will follow up with the RMO.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file. Where a patient had made an advance statement, this was also accessible in the file.

For patients who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act 2000 (AWIA), we saw copies of the legal order, apart from two files in Loirston Ward. We also found that in one patient's record there was a record of both a power of attorney (POA) and guardianship order being in place; it was unclear which legal framework was applicable. We brought this to the attention of the SCN on the day, and would suggest that this is picked up with the review of paperwork currently being undertaken by the lead nurse. Where a patient has a person legally appointed under the AWIA, to authorise welfare and financial decisions, staff need to accurately record the legal authority and ensure that a copy of the order is in the patient's file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. There were issues with several s47 AWIA forms and treatment plans; several had recorded the period of incapacity as being indefinite, which is not in line with the code of practice for medical practitioners. Some treatment plans did not have a record, or it was unclear, that the doctor had consulted with the legal proxy.

Recommendation 1:
Where a patient lacks capacity in relation to decisions about medical treatment, s47 certificates, and, treatment plans must be completed in accordance with the AWI Code of Practice (3rd ed.)

Rights and restrictions

Across both wards, the majority of patients were subject to detention under the Mental Health Act or Criminal Procedure (Scotland) Act 1995. Some patients on Loirston Ward have more complex needs, including sensory and non-verbal communication; they require more intensive support from staff due to their vulnerability

Both wards were locked, and we heard that this is due to the need to have safeguards in place for those patients who are detained under the Mental Health Act. For those patients who were in the wards on an informal basis, we discussed their rights and the impact of the locked door policy with the SCNs. We were told that patients and their relatives/guardians are informed of the reasons why the wards have this policy in place.

Section 281 to 286 of the MHA provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where we were told that restrictions had been placed on a patient, we found the appropriate documentation in the patients file that authorised this.

We were informed that all patients detained under the Mental Health Act had access to advocacy and that advocacy continues to have good links with the ward.

Where nursing staff were providing support to a patient under continuous observations, we saw detailed recordings of this, along with effective care planning, regular reviews and MDT discussion.

We wanted to follow up on our last recommendation regarding the need for a seclusion policy. On a previous visit in 2019 we had been told about, and reviewed a patient in the ward, where seclusion was being applied. We heard that seclusion was applied on occasions, however there was no policy in place. On our virtual visit in 2021 we were told that seclusion had not been used since the visit in 2019, however the plan was to develop an intensive support suite in part of Loirston Ward. We made a further recommendation on that visit that managers were required to develop a seclusion policy that gave clear guidance for the use of the suite. At this time, the suite has not yet been developed. We discussed a patient's care, as we were unclear if seclusion was being used, as some documentation recorded seclusion, however we were told that seclusion was not being applied.

We were told that there was a service group who were looking at a wider NHS Grampian seclusion policy however this was put on hold due to the pandemic. We have since been updated that the development of this policy continues to be on hold. We had a discussion with managers on the day of our visit and as this recommendation has not progressed, we will continue to actively follow this up with senior managers.

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

There are dedicated OTs for the wards who provide assessment-focused activities; this includes group and one-to-one activities. We saw that there is a weekly activity planner that is in place for all patients. Most of these activities take place out in the community or in the recovery resource centre which is based in Royal Cornhill hospital. We were aware from our last visit that Covid-19 had affected community activities for patients and how these restrictions had had an impact on patient routines. Patients were able to tell us how much they enjoyed being able to be back out in the community. It was good to hear from the patients and staff that since the lifting of restrictions, there is a greater range of community activities that are now more accessible than in the last two years, which are of benefit to the patients.

We noted that there was good recording in case notes of activities that were taking place and that there was a regular review of these with patients.

The OT staff continue to carry out assessments as part of each patient's discharge planning, supporting their re-integration back to the community. Both wards continue to have access to five vehicles to support community activities such as ten pin bowling, shopping and walking.

Although most activities occur in the community, both wards have their own activity area on the ward with gym equipment, TVs/game consoles and Strathbeg has a pool table.

The physical environment

Both wards are bright and spacious with ample seating/dining areas. Staff across both wards told us that they are still adapting to the new environment and have made some improvements to the ward to make the environment better for the patients.

Patients do not have access to kitchen/laundry facilities on the ward, which reduces the opportunities for rehabilitation and for patients to maintain the skills that they had prior to admission. Patients told us that they cannot make a cup of tea on the ward or do their own washing; they found this de-skilling. Patients, staff and relative told us about the difficulty with water pressure on the wards when trying to have a shower. Both wards have one shower and one bath for all patients. We were told that this causes difficulties for patients who are having to wait to access these facilities. This is more of an issue in Loirston Ward, due to the needs of the current group of patients.

OT and ward staff told us that they are currently trying to create a kitchen space in both wards to improve the environment for patients and to aid rehabilitation.

Strathbeg Ward has access to the garden as the ward is on the lower ground and we were told that there are plans to make better use of this area for patients. We were made aware of an incident that occurred and subsequently a new garden fence has been put in place. However, a broken window is still to be fixed.

Whilst patients can access the outside space in the hospital grounds, Loirston Ward has no access to a garden and we were told that this is being looked at as part of the functionality assessment.

We were told that the windows do not open in Loirston Ward which provides no fresh air to the ward, and this can be an issue for patients with sensory needs.

We were previously told that a functionality assessment was undertaken for both wards not long after the service moved from Elmwood Hospital to Royal Cornhill. We had asked for updates regarding the progress of this assessment, and the works that are planned as a result of this. However, we were disappointed to hear that the assessment has not yet been shared with both SCN's and other managers. We would like to be updated on the outcome of this assessment and will write to the senior managers for a copy of this.

Recommendation 2:
Managers should ensure that a request is put into maintenance to review water pressure to both wards and request to fix broken window in Strathbeg Ward as a matter of urgency.

Summary of recommendations

1. Where a patient lacks capacity in relation to decisions about medical treatment s47 certificates, and treatment plans must be completed in accordance with the AWI Code of Practice (3rd ed.)

2. Managers should ensure that a request is put into maintenance to review water pressure to both wards and request to fix broken window in Strathbeg Ward as a matter of urgency.

Good practice

While we were aware of the challenges faced by patients in relation to the Covid-19, we were equally aware of the impact that Covid-19 has had on staff. We were impressed to see and hear that the staff have continued to provide a quality service despite the numerous challenges presented to them, including staff shortages.

Service response to recommendations

The Commission requires a response to these recommendations within three months of receipt of this report.

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 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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