Mental Welfare Commission for Scotland

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

Date of visit: 9 June 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.

Corgarff Ward is a sixteen bedded mixed-sex slow stream rehabilitation ward that is based in the main Royal Cornhill Hospital. On the day of our visit there were 15 patients in the ward. Managers told us that 12 of the beds are been identified for patients who require rehabilitation, three beds are contingency beds and one bed is kept for a patient who may be referred from the community rehabilitation team. We were told that patients from acute services are likely to be transferred to the contingency beds, due to other pressures on services. We were told that where a patient may be nearing discharge, transfers are carried out in a planned manner.

We heard that during the Covid-19 pandemic, due to the pressures on the acute admission wards, Corgaff ward had a significant number of patients who were boarding from other wards, and the ward lost a sense of its identify around its main purpose of rehabilitation. However, we were pleased to hear that this has changed and the majority of patients who are being admitted or transferred to the ward, have been identified as requiring rehabilitation and meet the ward's admission criteria.

The rehabilitation ward was previously in Fraser ward and moved prior to the Covid-19 pandemic. We last visited the service on 30 May 2017.

On the day of this visit we wanted to speak with patients, relatives and staff. We also wanted to find out how the service was implementing the recommendations from the Commission's themed rehabilitation report that was published in January 2020.

Who we met with

We met with, and reviewed the care of seven patients, seven who we met with in person and six who we reviewed the care notes of. We also met with two relatives.

We spoke with the senior charge nurse (SCN), ward staff and clinical nurse manager

In addition we made contact and spoke with the local advocacy service based in the hospital.

Commission visitors

Tracey Ferguson, social work officer

Claire Lamza, executive director (nursing)

What people told us and what we found

Care, treatment, support and participation

We found that for individuals in Corgarff Ward, many had been in hospital, and in the rehabilitation service for several months, and for some, the duration of their stay has been over a period of years, due to their complex and enduring mental health needs. Although some patients had been in the ward for a lesser period of time than others, many patients had been in other wards before being transferred to Corgaff Ward. Some patients also had previous stays in hospital that had lasted for years.

Throughout the day of our visit, we spoke with most patients in the ward. Feedback from patients was mostly good, however a few patients told us that they wanted to go home and felt restricted on the ward. Some patients told us about the activities they like to do, especially with the occupational therapist (OT), whilst other patients told us about the good relationships that they have with staff. It was difficult to engage with some patients due to their presentation on the day and some patients told us that they did not wish to speak with us. Relatives told us that they were happy with the care that staff provided and that communication was good however, relatives commented about the lack of activities available and their involvement in their relatives care and treatment.

The SCN told us about the ongoing staffing challenges in trying to fill vacant posts and we recognise that recruitment of nurses is a national issue. We heard about the continued proactive efforts to recruit staff and how the ward currently uses regular bank nurses, to ensure continuity and safe delivery of patient care. We were pleased to hear that the service has recently recruited four new members of nursing staff, reaching their full staffing compliment of eight trained staff members.

Nursing care plans

Of the patient files we reviewed, we saw detailed holistic nursing assessments that were completed on admission, along with reviews that were updated regularly; these included risk assessment and risk management plans. We spoke to the SCN about the importance of ensuring that updates in the assessments captures all information.

Each file provided a list of key professional contacts that were involved in each patient's care. Where advocacy was involved, we suggested that this should be documented in the list of key contacts and clearly visible in the file.

We found evidence of physical health care monitoring being provided throughout the patient's journey and were told that the GP visits the ward weekly to discuss patients physical healthcare needs, which was recorded in the patients' files.

Most files had completed the 'Getting to Know Me' booklets that staff had gathered in one-to-one sessions with the patient or with help from relatives.

Care plans were reasonably detailed, including interventions and evaluation. However, the plans lacked definition and detail in relation to rehabilitation goals. We found it was difficult to see where the patient had progressed during their rehabilitation journey. The care plans had

been developed from generic documents used throughout NHS Grampian mental health services and lacked a focus on rehabilitation. We had a further discussion about the documentation with the SCN and clinical nurse manager on the day.

We were aware that the current documentation is limited for staff to use, and this was highlighted in a previous visit to another service area although the care planning documentation does consider the needs and strengths of the patient, which is helpful. We noted that some patients had signed their care plans and it was recorded where others had refused to sign.

We were told that NHS Grampian will be moving to electronic recording in the near future which will provide an opportunity for the service to develop standardized rehabilitation-focused documentation.

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/node/1203

Multidisciplinary team (MDT)

When patients are treated in a rehabilitation service we would expect that they have access to a full range of professionals that are involved as part of a multi-disciplinary team (MDT), and who provide the requisite skill mix to deliver care that is focussed on rehabilitation.

This ward has a rehabilitation consultant psychiatrist and a ST6, speciality trainee doctor. The consultant psychiatrist also covers the community rehabilitation team, which ensures continuity for patients following discharge. We were told that multi-disciplinary meetings (MDT) continue to take place weekly. The meetings are attended by the consultant psychiatrist, nursing staff, occupational therapy (OT) staff, clinical psychology and pharmacy. We were pleased to see that there was involvement from the MDT in the planning and delivery of patients' care. We also found that where patients required input from other specialisms such as physiotherapy and dietetics, that this had been identified, discussed in the MDT and these services had been accessed as part of the patients' care and treatment.

In the MDT record we saw that there was a recorded entry of who attended, along with a detailed nursing entry that provided the update for the meeting. However the MDT minutes were variable in the level of detail recorded, particularly around patient outcomes and actions. We asked about other types of meetings that were in place to review the patients' rehabilitation plans. We were told that there is a review meeting every 12 weeks where social work staff are invited. We heard that some patients have other review meetings however, there was not a standardised format in place that was consistent.

We had a discussion with the managers about the standardised process for reviews of patients who have complex mental and physical health care needs and felt that it would be beneficial for the ward to consider approaches such as the Care Programme Approach (CPA) which provides a robust framework for managing patient care or using an Integrated care Pathway (ICP) approach.

We wanted to find out about patient pathway to the community. We were told that some patients may be referred to the community rehabilitation accommodation at Polmuir Road and others may move directly onto supported tenancy in community. The community rehabilitation team would follow these patients up, and link in with the ward prior to discharge.

Recommendation 1:

Managers should ensure that review meetings are built into the patients' rehabilitation journey, at the three-, six-, and 12-month intervals where necessary.

Use of mental health and incapacity legislation

Eight patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act and of the files we reviewed we found that the MHA paperwork was in order.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the MHA were in place, however we found a few discrepancies with two patient's treatment and we followed this up on the day with the SCN.

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.

When we are reviewing patient files we looked for copies of advanced statements. The term 'advanced statement' refers to written statements made under ss274 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 found recordings in patients' notes, where a patient did or did not have an advanced statement in place. Where it was recorded that a patient did not have one in place, there appeared no follow-up discussion since the patient's admission in relation to this. One of the recommendations from the Commission's themed rehabilitation report was for NHS Boards to develop plans to promote understanding and the use of advance statements in rehabilitation services. We had a further discussion with the SCN about this and felt it would be beneficial for the service to build in these discussions into the patient's rehabilitation journey, and continue to work alongside advocacy services, who could help promote patient's rights.

For patients who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000(AWIA) we saw a copy of the legal order in most patient files, apart from two. There were also some entries that recorded that the patient was subject to AWIA, rather than noting the specific legal order. We raised both of these with the SCN, as this lack of clarity regarding the measures authorised under AWIA legislation could lead to confusion.

Where patients are assessed as lacking capacity to consent to treatment and they are being provided with treatment under Part 5 of the AWIA, section 47 certificates authorising treatment should be completed. The certificate is required by law and provides evidence that

treatment complies with the principles of the Act. We were pleased to see that all patients, where required, had a section 47 certificate and treatment plan completed. However there was one treatment plan that had also recorded welfare and finances. A section 47 certificate provides authority only for medical treatment under part 5 of the AWIA and does not provide legal authority regarding welfare matters. We also brought this to the attention of the SCN.

https://www.mwcscot.org.uk/sites/default/files/2021-10/Scope-Limitations-S47_advice2021.pdf

Rights and restrictions

The door to the ward was locked and we were told that this has been in place since the Covid-19 pandemic. We found that this hindered patient's access to and from the ward and saw that it had an impact on staff time, who were required to open and lock the door. We understand that the Covid-19 pandemic restrictions have had an impact on patient's ability to access the community, however given that restrictions have been lifted for some time, it was important that patients access is not restricted any longer than necessary, especially for informal patients. The SCN told us on the day of the visit that there has now been agreement for the ward door to remain open.

S281 to 286 of the MHA provides a framework in which restrictions can be placed on patients who are detained in hospital. Where a patient is a specified person in relation to these sections of the MHA, and where restrictions are introduced, it is important that the principle of least restriction is applied. We found paperwork in two of the files, where the review timescales in the reasoned opinion documentation was not in line with the guidance. We found that a patient had been made a specified person in order to limit their food intake. We discussed this further with the managers on the day as we felt this was not the appropriate legal framework in place for such restrictions. The Commission would expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed, along with reasoned opinions to be documented in the files.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

Recommendation 2:

Managers must ensure where a patient has been made a specified person that reasoned opinions along with regular reviews are in place and that where a patient has been made a specified person that this is in line with the legislation.

The ward has good links with the local advocacy service who are based in the Royal Cornhill Hospital. From the files that we reviewed, we were able to see where patients had support from an advocate at meetings and tribunals.

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

Many of the patients in the ward have spent long periods of time in hospital, which can significantly affects their skills and abilities needed to live back in the community. We would expect that a specialist inpatient rehabilitation services would have individualised activities to promote recovery, and that has been recorded in activity planners/timetables that would help patients gain or regain the skills and confidence needed to progress their recovery.

We are aware that during the pandemic, restrictions that were required to be put in place have had an impact on various activities out with the ward and that some of the patient group have found this change to their routine difficult. However, we were pleased to hear about the efforts of nursing staff to ensure there was always activity available on the ward for patients.

We were told that the ward has dedicated input from OT to provide therapeutic-based activities on a one-to-one basis and in groups. The ward also has an activity nurse that is shared with another ward and who provides activities 1.5 days per week.

Some patients were able to tell us about their activities and the groups they attended, while others told us that there was not enough to do. Relatives were unsure of the activities on offer or being provided to their relative and did not feel that the ward provided enough activities on and off the ward as part of the rehabilitation plan.

Although we were told of activities being provided and offered, we found that there was a lack of recording in patient's notes about the activities that were offered and how these benefitted the patient as part of their rehabilitation. We found that not all of the patients had an individualised planner/timetable in place, and in those cases, it was unclear as to how activities were contributing to the overall rehabilitation plan.

We did find detailed OT assessments in patient's files and the OT's recordings of activities, such as breakfast and lunch groups, as well as art groups.

The ward has a new patient kitchen that has just been completed, with areas where the OT and staff can work with patients, in regaining their skills around activities of daily living. At present the patients require to go off the ward to access such facilities so this is a positive step and an exciting addition to the ward. We look forward to getting an update in the future.

Recommendation 3:

Managers must ensure that each patient has an individualised activity planner in place as part of their rehabilitation journey.

The physical environment

The layout of the ward consists of single rooms and shared dormitories, along with a large dining/sitting area that leads out to the enclosed garden area. There are ample shower/bathroom facilities and facilities for patients to do their own washing, however the laundry room is out with Corgarff and shared with another ward.

The garden was being used by patients on the day of our visit, but mainly for smoking. Although there were bins for cigarette ends, many of these were lying around the garden

entrance. We were told that patients are allowed to smoke in this area however the SCN told us that there is ongoing work being done in the garden. We heard that when this is are completed, patients will no longer be permitted to smoke in the garden area and will be required to go off the hospital grounds, as per NHS Grampians policy.

Summary of recommendations

1. Managers should ensure that review meetings are built into the patient's rehabilitation journey, such as at the three, six and 12 monthly intervals, where necessary.

2. Managers must ensure where a patient has been made a specified person that reasoned opinions along with regular reviews are in place and that where a patient has been made a specified person that this is in line with the legislation.

3. Managers must ensure that each patient has an individualised activity planner in place as part of their rehabilitation goals.

Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving 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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