Mental Welfare Commission for Scotland

Report on announced visit to:

Brodie Ward, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 10 November 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.

Brodie Ward is based in Royal Cornhill Hospital and specialises in caring for male and female patients who have an acquired brain injury or neurological disorder with severe psychological and behavioural symptoms.

The ward can take up to 10 patients, however on last year's visit the senior charge nurse (SCN) told us that bed occupancy had been reduced to eights beds due to the Covid-19 pandemic. On the day of the visit there were 10 patients in the ward, and we were told that two of the patients were 'boarding' from another ward, due to the lack of available beds in the general adult psychiatry inpatient wards. The ward had a mixture of single rooms and dormitory accommodation and had been arranged so all patients had a room to themselves, however due to the ward admitting 10 patients, this meant that some patients had to share. We were told that due to the increase in patient numbers, this had also directly impacted on the therapeutic space available in the ward.

We last visited this service on 14 September 2022 and made no recommendations.

On the day of this visit we wanted to speak with patients, relatives/carers and staff.

Who we met with

We met with and reviewed the care notes of five patients. We also had contact with three relatives/carers. In addition, we made contact with the local advocacy service based in the hospital.

Prior to the visit, we held a virtual meeting with the charge nurse (CN) and consultant psychiatrist. On the day of the visit, we spoke with the service manager, SCN, ward staff and clinical nurse manager. Information was also provided from the occupational therapist (OT).

Commission visitors

Tracey Ferguson, social work officer
Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

Throughout the day of our visit, we spoke with and introduced ourselves to most of the patients in the ward. We were told that some of the patients had been in the ward for a considerable period of time and presented with very complex physical and mental health needs, as well as limited verbal communication. Staff told us that due to the nature of some patient's illness, their involvement in social, recreational and therapeutic activities can at times be limited.

Patients we met with told us that the staff team are good, caring and approachable. Where patients expressed to us that they did not want to be in hospital, they were able to tell us about their rights and the supports they had in place from services such as advocacy. Relatives/carers told us that the communication was good and they knew who to speak to if there were any issues. Some patients were able to tell us about their weekly activities and how they enjoyed the activities on and off the ward.

We observed positive interactions between staff and patients during the visit, spoke to staff throughout the day and were able to see that the staff team knew the patients extremely well.

Nursing care plans

When we last visited the ward we found examples of detailed and person-centred care plans that addressed the full range of care for mental health, physical health, and the more general health and wellbeing of patients. On this occasion, we mostly found detailed person-centred care plans, with evidence of review and evaluation. We saw where care plans had been updated following the review process, along with evidence of patient involvement. Some patients had signed their care plans and some care plans had recorded that the patient was unable to sign. We had a discussion on the day with managers of the importance of reviewing this throughout the patient's journey.

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

We found detailed information contained in patient's regular one-to-one discussions with their named nurse, which was meaningful. Where a patient did not want to engage, this was also recorded.

We also noted that the mental health assessments were comprehensive, and that risk assessments and risk management plans were reviewed regularly throughout the patient's journey and updated where necessary. We saw some detailed 'Getting To Know You' documents in patient files that gave a clear account of the patient's history, outlining their likes, and dislikes.

Multidisciplinary team (MDT)

We were told that the MDT meetings took place weekly and the MDT consists of a consultant psychiatrist, nursing staff, occupational therapy (OT) staff and a clinical psychologist. We also

heard that pharmacy provided regular input to the MDT. The ward continued to have regular input from the GP to assist with physical health matters and they were also part of the weekly MDT meetings.

On our last visit, the consultant psychiatrist was newly appointed and we heard from staff and advocacy services of the positive impact and benefits to patients, having this consistency throughout their patient journey.

Managers told us that the current provision of OT input to the ward had been slightly reduced and we heard about the ongoing challenges with OT recruitment and retention. We were told that there was a review of OT provision across all wards, and we would like to know the outcome of this and will link in with divisional lead OT.

We were also told that the clinical psychologist recently left their post, which had created a vacancy that was soon to be advertised.

Although we were told of these recent changes with the MDT, on reviewing files, we saw input from OT and psychology and we were able to see the plans and assessments in place that had continued to be implemented by the staff, which was positive.

The consultant psychiatrist told us that the ward was piloting an electronic recording of the MDT minute. We viewed minutes of the MDT meetings and were able to see who attended these meetings, along with meeting discussions and outcomes, except for the two patients who were 'boarding' from another ward. We were told that there was an agreement in place between the services, in that the nursing staff in Brodie ward would update the responsible medical officer (RMO) in the acute services, following the MDT meeting. We were also told that the consultant psychiatrist or nursing staff get in touch with the RMO to request a review of the two patients, when necessary.

We were told that there were three patients who have been identified as delayed discharge and we heard that there are discharge planning meetings that take place with the MDT, including social workers, and relatives/carers. We discussed one case with staff on the day of the visit, as it was difficult to see what discharge planning and progress had been made, as the patient was boarding in the ward, and there was a lack of recording in their file about progress of discharge. Although there was an agreement in place, we advised that both services need to have a clear protocol in place to ensure that patients care and treatment was reviewed regularly along with progress of any discharge planning and that patients who are boarding in another ward receive the same standard of care, treatment and attention to their needs as every other patient.

In patients' notes, we could see that there was attention given to patient's physical health care needs. We also found that where patients required input from other healthcare professionals, that this had been identified, discussed with the MDT and these services had been accessed as part of the patient's care and treatment.

Use of mental health and incapacity legislation

Eight patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) and of the files we reviewed we found that the Mental Health Act 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 Mental Health Act were all in place.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity Act (Scotland) 2002 (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. Section 47 consent to treatment certificates were mostly in order along with accompanying treatment plans, apart from the two patients who were boarding. The two certificates and treatment plans were not completed in accordance with the Adults with Incapacity code of practice for medical practitioners. Where a proxy decision maker had been appointed the medical practitioner must consult with the welfare guardian or power of attorney. One certificate had recorded that the financial guardian had been consulted and not the welfare guardian. We followed this up on the day with SCN and requested that these two certificates were reviewed.

We discussed a patient's consent further with the SCN. The patient had been assessed as lacking capacity for treatment for physical care but not mental disorder, therefore it was important to clearly record this in the patient's care plan, with regular reviews taking place.

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

Where a patient had an appointed legal proxy under the AWI Act we saw copies of orders in the patient files, apart from one where the most up-to-date order was not in the file. We followed this up with the SCN on the day.

Rights and restrictions

The door to the ward was locked and there was a locked door policy in place, however this was not clearly displayed for patients or visitors. Where patients are admitted to the ward on an informal basis it is important that patients are aware of their rights, including access to and from the ward. We discussed this further with the SCN on the day who agreed to follow this up, to ensure the information about the locked door policy was accessible for all patients.

S281 to 286 of the Mental Health Act 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 were told that one patient had been made a specified person, however the paperwork was out of date. We brought this to the attention of the SCN on the day.

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 at:
https://www.mwcscot.org.uk/node/512

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

When we are reviewing patient files we looked for copies of advance statements. The term 'advance 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 entries in patient's notes, detailing where a patient did or did not have an advance statement in place, and saw a copy of the advance statement

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

Activities were carried out by ward staff, OT and the activities co-ordinator. The ward had an activities co-ordinator two and a half days per week and we were able to see recordings of activities in patient's notes. These were happening regularly and where a patient had been in hospital for a significant period of time, they had an individualised planner in place. On our visit last year we felt that the recording of activities could be more outcome-focussed as opposed to recording the description of the activity. Although we saw improvement in this area, we had a further discussion with the SCN about the recordings and how these would benefit from being more meaningful.

The ward had access to a vehicle to take patients out in the community, which staff and patients told us they enjoyed.

Some patients were able to tell us about their activities and the groups they attended, and how they enjoyed these. The ward had a pool table and on the day of the visit, patients were participating in games. It was good to see the importance of therapeutic activities in patients care and treatment, however we were told that the OT reminiscence group was no longer taking place due to the lack of therapeutic space in the ward, and since the patient occupancy had increased.

The physical environment

The ward compromised of single en-suite rooms and dormitories. Due to the increased capacity in bed numbers, we were told that two patients were having to share a dormitory. Staff told us about the impact on patients having to share accommodation and that there was no separate space in the ward for activities. The room that was previously used for activities

was now being used a sleeping area. One of the dormitories was being used for storage space, and included patient's wardrobes, staff break out area and storage of arts, crafts and ward equipment.

There was a dining area where patients could have their meals with access to an enclosed garden area. We saw that some work had been done in the garden area since our last visit and heard of other future plans. The garden requires to be accessible for all patients given the nature and purpose of admissions to the ward, where many patients may have wheelchairs. The door to the garden area was alarmed however we were told that this is in the process of being removed to enable patient's easier access.

We saw some patients had personalised their bedrooms, with pictures on the walls and televisions in their rooms.

We heard that a report had been submitted to senior managers for approval to keep the bed capacity at eight, ensuring that the ward only admitted patients who meet the ward criteria. The increase in patient numbers has had an impact on patient's privacy and dignity, as patients no longer have their own room. We were also told of some environmental changes that were required in order to meet the mental and physical needs of patients. The Commission is aware of the current pressures in acute services, however we would be concerned if patients who do not have an acquired brain injury or neurological disorder continued to be admitted to this ward.

We heard from staff that it was difficult and challenging where patients had different RMO's, other than the psychiatric consultant who covers Brodie ward. We found that the quality of documentation, along with the review of the patients care and treatment, including restrictions, was not consistent, due to these patients having RMO's elsewhere in the hospital. We will therefore continue to link in with senior managers regrading this matter.

Recommendation 1:
Managers must develop a clear protocol between Brodie ward and other general adult psychiatric wards which supports robust communication, along with recorded evidence of discussed and agreed clinical decision making for all patients who are boarding in Brodie Ward.

Summary of recommendations

Recommendation 1:
Managers must develop a clear protocol between Brodie ward and other general adult psychiatric wards which supports robust communication, along with recorded evidence of discussed and agreed clinical decision making for all patients who are boarding in Brodie Ward.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the date 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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