Mental Welfare Commission for Scotland

Report on unannounced visit to:

Huntly, Fraser and Dunnottar Wards, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH

Date of visit: 13 and 14 March 2023

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 unannounced visit was carried out face-to-face.

We visited the three adult acute mental health psychiatric admission wards; Huntly, Fraser and Dunnottar that were based in Royal Cornhill hospital. The three wards received admissions based on geographical area. Huntly Ward had a catchment area predominantly that covered Aberdeen City; Fraser Ward had a catchment area that covered Aberdeenshire and Orkney and Dunnottar Ward covered Aberdeen city, Shetland and the Ministry of Defence. Managers told us that patients were often admitted to a ward that was out with the patients' geographical catchment areas; however, when a bed became available, efforts would be made to transfer the patient to the appropriate ward.

Each ward had 21 beds and were all mixed-sex wards, with a mixture of single rooms and dormitory accommodation. On the day of this visit, all three wards were at full capacity. We had been made aware prior to this visit that the bed capacity had increased in each ward to 23, and that this was in response to clinical need across all the areas. We were also told that there were a number of patients that had been boarded to other wards across the Royal Cornhill site, due to there being no availability in the adult acute wards. Staff and clinicians expressed concern about this, particularly around the difficulty and challenges in reviewing patient care and monitoring patient progress.

Managers told us about the significant staffing challenges, along with the demand and capacity for admission beds across the service, and that these challenges had continued and had significantly increased since the Covid-19 pandemic. With a rise in the number of admissions due to clinical need, managers told us how they had continued to have a daily huddle to discuss bed pressures, patient admissions and discharges, along with staffing numbers, to ensure safe delivery of patient care.

We were told that there was a high number of staffing vacancies across the service and that there continued to be a recruitment drive to fill vacant posts. Since our last visit, two psychologists had been recruited to the service, providing input across all three wards. Although those posts joined the service fairly recently, the nursing staff told us that they had already seen the positive benefits to patient care and treatment and to the wider multi-disciplinary team (MDT) with this new added provision.

We heard from the managers that the service was in the process of recruiting three health care support workers and that those posts would focus solely on activity provision across the three wards, with evening and weekend cover included. We look forward to hearing about this added provision on our next visit.

We last visited this service on 21 September 2021 and made a recommendation in relation to Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) treatment

certificates. We received a response from the service that included an action plan as to how the service planned to make those improvements.

On the day of this visit, we wanted to follow up on the previous recommendation and to hear about the patient's experience across the wards. The Commission had been notified of the increased bed capacity and had been made aware of patients that had experienced several moves between wards during their stay. We had also received some calls to our duty advice line regarding patients who had been boarding to other wards, and concerns raised regarding the lack of overview of those patient's care and treatment.

We wanted to hear about patients' experience of discharge planning and processes that were in place; we had been made aware of situations where patients had been discharged without formal discharge planning meetings, and in some cases, this may have contributed to re-admission.

Since our last visit, the Commission had received notifications from the health and social care partnership (HSCP) and NHS Grampian of significant incidents that had occurred in the service and therefore we wanted to look further at the wards risk management documentation and decision making process about risk.

Who we met with

When we plan a visit, prior notice is given to patients and relatives of our intention to visit. Given that this visit was unannounced, we were unsure if we would have the opportunity to speak with relatives, however we managed to speak with a relative and we spoke with and/or reviewed the files of 32 patients across the three wards.

We spoke with lead nurse, senior charge nurses (SCNs), ward nursing staff and clinicians. As this visit was unannounced, we had a separate meeting following our visit with senior managers of NHS Grampian

Commission visitors

Tracey Ferguson, social work officer

Anne Buchanan, nursing officer

Lesley Paterson, senior manager

Graham Morgan, participation and engagement officer

Alyson Paterson, social work officer

Dr Juliet Brock, medical officer

What people told us and what we found

Care, treatment, support and participation

We found that patients across the three wards were at different stages of their recovery journey. We were told that some patients had recently been admitted to the wards, and others had been in for a longer period. There were a higher number of detained patients across all the wards, compared to our previous visit. Due to increased levels of risk and acuity of mental ill heath, some patients had been placed on continuous intervention and required a higher level of staffing intervention. We were told that there were more patients in Fraser Ward who required support with their physical healthcare needs, which placed greater demand on nursing time. Staff told us about the impact this had on their availability to spend time with other patients in the ward.

We heard from patients about their admission process and how they were often admitted to a ward out with their geographical area, and not knowing when they would be transferred. Some patients told us about the difficulties of being in a different ward, and not having the opportunity to meet with their consultant psychiatrist, often unsure as to who was reviewing their care and treatment.

Across all wards, most of the patients that we spoke with told us that there was not enough to do, which often led to boredom. We heard that the ward environment was not therapeutic from some patients and the relative, with a focus being on medication as the only aid to support recovery. Some patients told us about groups and activities on and off the ward that they attended, however we heard about this from only a few patients across all three wards. A patient in Huntly Ward suggested to us, that if there was more to do and patients were provided with appointments with psychology and psychiatry, the overall ward would improve.

We heard from some patients that we spoke with of their sense of not feeling involved in their care and treatment. Some patients told us they had never met with a doctor, where as some others told us that they met with their doctor regularly. Patients and the relative described communication as poor between the staff, doctors and patients. The feedback was mixed across all the wards.

All patients we spoke with commented on how busy it was in each ward. Some patients who had had previous admissions told us that they had never seen the wards so busy. Patients were sympathetic to the situation, however many reported that this affected their situation as they did not want to bother staff; one patient in Dunnottar Ward described feeling “invisible”.

Some patients we spoke to in Dunnottar Ward told us that the staff were friendly, skilful and caring. One patient described the nursing staff as “the best”. Some patients’ feedback about Fraser Ward told us that there had been many changes in the staff team, which made it hard to establish positive therapeutic relationships. Patients described the staff as lovely and very busy. Some patients in Huntly Ward described staff as approachable, “always looked out for you” and easy to talk to. Others told us that it was not easy to speak with staff because they were busy with other patients, so for some patients, it was hard to know what was happening and to “know when the psychiatrist would attend to you”.

Some patients across the three wards told us that they had regular one-to-one meetings with staff, whereas others told us they approached staff when they needed to. Other patients and the relative told us that they often initiated the request to meet with nursing staff and the consultant psychiatrists.

We asked the patients about the meals delivered to the wards and reports were variable. One patient in Huntly Ward described the food as "super", whereas a patient in Dunnottar Ward described the meals as "horrendous, processed food". Another patient suggested that more fresh fruit should be available on the ward.

We heard on our visit last year that there had been an increase in patients who had been admitted with increased levels of acute mental health symptoms than prior to the pandemic, with patient's recovery taking longer. Similarly, we heard this again on this visit from nursing staff, consultant psychiatrists and the patients.

We spoke with some patients who had been re-admitted back to the ward, shortly after discharge. Some patients told us that they did not feel ready to be discharged, whilst others told us that they felt unsupported in the community. We had a further discussion with the SCN regarding one case, where it had been brought to our attention that a patient who had been granted a pass from the ward for a few days had been due to return to the ward, however the patient's pass had to be extended, as the patient no longer had a bed in the ward. The patient had been classed as 'boarding on paper' to another ward, outwith the acute services, which raised concerns regarding the decision making process, as it appeared to be in response to bed capacity, as opposed to a clinical decision based on the patient's recovery.

Care planning and documentation

The Commission had made a previous recommendation regarding care plans following our visit in 2019 and followed up on this during our visit in September 2021.

During our visit in 2021, we heard about the continued frustration of staff around the ability to record information in the Grampian admission booklet, specifically in relation to the limited space provided in the document, available for care planning. We had been told during our visit in 2021 that a short life working group, which had been set up to review the documentation, had to be put on hold due to the Covid-19 pandemic. Following our visit in 2021, managers had given a commitment to starting this group. However we were told that no progress had been made with regards to the short-life working group due to other commitments and priorities.

On this visit we saw some evidence of detailed care plans, in the three wards, which identified recovery goals that patients were working towards, however this was not consistent across the three wards. The recordings in a number of care plans was more generic, for example 'monitor mental state' or 'fully assess mental state'.

Although there was evidence of regular care plans reviews, it was difficult to know how progress was being monitored between each review, as there was no evidence of summative evaluation and recording of treatment goals was limited; we found that this was the case in all three wards. Not all care plans were holistic, about patients physical and mental health needs. Furthermore, patients' participation in care planning was lacking and it was unclear

when this was revisited throughout the patients' journeys. We saw that staff had recorded in some files where a patient refused to sign their care plan or engage in the process, where staff recorded 'refused to sign'. There was some entries where it was recorded 'unable to sign'. We emphasised the importance of staff continuing to review patients' participation in the care planning process, throughout various stages of their journeys. We spoke to patients about their care planning and where some patients were able to tell us of their involvement, others told us that they had been asked to sign the document, without any input or involvement in the process.

We asked managers about the audit process that was in place, however we were told that audits were not being completed.

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

Recommendation 1:
Managers should ensure that there is a regular audit process in place in order to improve the quality of care plans and ensure that they reflect and detail interventions which support patients' movement towards their care goals, along with regular reviews, summative evaluations, and evidence of patients' and carers' involvement.

Where we found evidence of one-to-one discussions in patients' files, we found this was detailed across the three wards and provided information relating to progress and improvements in each patient's mental state. However, the frequency and existence of one-to-one discussions was inconsistent across the wards. In each ward, we found some patients had regular sessions, whereas others had none recorded. It was unclear if the patients had been offered and refused, or if they had not been offered at all.

Some of the language recorded in patient notes, across the three wards, did not provide enough detail about the care that was being delivered to this patient group. Phrases described patients as 'brittle' and 'argumentative', and were recorded in patient notes without any context. This did not appear to give enough information about those patients with mental ill health. Some nursing entries were minimal and recorded phrases such as 'kept a low profile' 'settled day' or 'minimal interactions'. It was therefore it difficult to determine whether staff would expect the patient to initiate interactions or whether staff encouraged engagement.

Recommendation 2:
Managers should ensure that nursing entries in patient records comply with the Nursing and Midwifery Council Code, Professional Standards of Practice, and Behaviour for Nurses, Midwives and Nursing Associates.

In the patients' files, detailed nursing assessments had been completed at the point of admission, along with risk assessments and risk management plans. We saw that these had been reviewed, however we found some that required to be updated or re-written due to the multiple updates on the record. Risk assessment and risk management plans highlighted relevant risk areas, and there was evidence of ongoing review, however we found that not all

reviews were taking place regularly, nor did they reflect the identified risk in accordance with the nursing updates and entries in patients notes. We had a further discussion with managers about the risk assessment and risk management plans of two patients, due to the concerns we had when reviewing patient notes.

Recommendation 3:
Managers must ensure that all risk assessments are regularly reviewed, updated, and discussed within the MDT meeting to ensure they accurately reflect the patients' assessed risk and that an agreed risk management plan is formulated.

Multidisciplinary team (MDT)

Each ward had a weekly MDT meeting and we were told that all patient care and treatment was discussed at these meetings. Dunnottar Ward and Huntly Ward had a permanent consultant psychiatrist that covered the wards, providing continuity of patient care. However, we were told that since our last visit, the medical cover in Fraser Ward had been provided by locum consultants. Managers told us about the ongoing staffing challenges in trying to fill vacant consultant psychiatrist posts and we recognised that there has been an issue nationally in the recruitment of consultant psychiatrists.

We were told that the three wards had an MDT document that was completed at the meeting. The template appeared to be robust in that it recorded attendees, and had a variety of sections that included patients' progress and updates, treatment certificates, patients' views/requests and legal status. However, on reviewing files, we frequently found only attendees' first names were recorded and that the standard of completion of the document varied across the three wards. We found that the record lacked detail regarding patient progress, with it being difficult to determine whether there had been any progress from week to week. One MDT document in Huntly Ward recorded 'patient evident around the ward' in the weekly progress section. From reviewing the nursing and medical notes of a patients care, we had been alerted to recent high-risk behaviours on Dunnottar Ward, however there was no reference to those significant incidents in the weekly MDT meeting record or in the rapid risk assessment, which we were told was a dynamic document.

The Commission was aware of an action plan which had been developed following a significant adverse event in the adult acute service. An action from this was to ensure improvement in the recording of all first and surnames of professionals attending each MDT meeting. We were concerned, as it was evident from this visit that the improvements had not been fulfilled.

We were unsure about patient participation during the MDT meeting and were told that patients tend not to be invited. We heard in Dunnottar Ward that all 23 patients were discussed over the course of one morning and that time pressures would not allow for patients to attend.

We saw a section on the MDT record for patients' views, however the majority we reviewed were blank. We did find some examples across the three wards where patients' views had been sought in advance of the meeting, however from reviewing the records we found that patients' views were not discussed at the meeting and the patients were not always involved and given the opportunity to be involved in the ongoing discussions about their care and treatment.

A few patients told us that they met regularly with their consultant and that they had known them for years and had built up a good relationship; others told us that it had been a while since they last saw their consultant. We heard from some patients that they found it difficult being boarded to another ward as they did not always see the regular consultant. Nursing staff told us that they do try and transfer patients back to their geographical ward as soon as possible, if appropriate, and that the consultant would remain the patient's responsible medical officer (RMO) wherever they were boarding to. However, due to the increased admissions, along with the increased bed capacity we were told that there were a higher number of patients boarding in other wards. This caused difficulties, including the time constraints for consultants to review patients across multiple hospital wards.

The wards continued to have input from occupational therapy (OT), however managers told us that since the Covid-19 pandemic, this input to the ward had changed due to a shortage of OTs across the service area. Managers and the SCN told us that the OT still had regular input with patients, providing assessments and activities and continued to attend the weekly MDT meetings, where necessary.

The new addition of psychology input to the service was a much welcomed and needed development and we were told staff and patients had already benefitted from this addition. We look forward to hearing about the progress of this resource on our next visit.

Recommendation 4:
Managers should develop a mechanism to ensure patients and/or relatives are able to have their views considered at the MDT meeting and that feedback is given to patients and/or relatives following the meeting.

Recommendation 5:
Managers should regularly audit the MDT record documentation to ensure that it clearly documents attendance, discussions, decision taken and record patients' and/or relatives' participation.

Care records

Patient notes were in paper format, and each file was organised with separated sections for information and easy to navigate around. We continue to hear about the plans for NHS Grampian to move to a new electronic system in the near future. We were told that there was ongoing pilot sites testing the system, in the hospital, however there was no planned date for this to be rolled out to the acute services as yet. Due to the ongoing concerns regarding the lack of progress in relation to care planning and other documentation, we suggested to managers that they need to ensure that the new electronic system will fully meet their needs and lend itself to robust and detailed recording.

Use of mental health and incapacity legislation

On the day of our visit, 44 patients, across the three wards were detained under the Mental Health Act. 14 patients were detained in Dunnottar Ward, 11 patients in Fraser Ward and 19 patients in Huntly Ward. All documentation pertaining to patients Mental Health Act detention was in place and up to date.

We wanted to follow up on our recommendation from last year's visit about Mental Health Act treatment forms. 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. Our medical officer reviewed all patient treatment forms, along with medication prescription kardex, across the three wards. We found significant issues with the treatment forms (T2 and T3) that required completion by the responsible medical officer (RMO) to authorise treatment under the Mental Health Act. Where a patient was prescribed high dose antipsychotic medication, we found that all patients did not have a high dose monitoring form in place, as would be expected.

In Dunnottar Ward we found discrepancies with seven patients' treatment. Out of the 14 patients that had been detained, five of those patients had been detained for more than two months and a T2/T3 certificate was required to be in place; we found no evidence of any T2/T3 certificate in the patient's file. We also highlighted a concern with regards to a patient who had received high dose antipsychotic medication without the required monitoring in place. We found that a further two patients had a T2 in place, but that not all the prescribed psychotropic treatment was authorised, and some of the prescribed medication included intramuscular (IM) medication.

In adult acute admission wards, administration of 'as required' IM psychotropic medication almost always requires the legislative authority of the Mental Health Act. Our view is that it is unlikely that a patient would consent to IM medication being given urgently for agitation, as deemed necessary by clinical staff.

In Fraser Ward we found discrepancies with three patient's treatment. Out of the 11 patients that had been detained, five of those patients had been detained for longer than 2 months therefore a T2/T3 certificate was required, but there was no evidence of T2/T3 in patients' files for three of the patients. We also highlighted a concern with regards to a patient who had received high dose antipsychotic medication, with no high dose monitoring in place.

In Huntly Ward we found discrepancies with eight patient's treatment. Out of the 19 patients that had been detained, eight of those patients had been detained for longer than two months therefore a T2/T3 was required, but there was no evidence of T2/T3 in patients' files for eight of the patients. We also highlighted a concern with regards to a patient who had received high dose antipsychotic medication, with no high dose monitoring in place.

NHS Grampian managers had submitted an action plan to the Commission as to how the previous recommendation were going to be met, this was required to improve practice and governance with regards to patient treatment. We had significant concerns with the number of treatment issues across all three wards, particularly with the lack of regard to patient rights and safeguards that are embedded in Mental Health Act legislation.

The Commission had previously advised the service that a copy of all treatment forms should be kept together along with the drug prescription sheet, in order for nursing staff to check that all treatment was authorised, when administering medication; we were disappointed to see this was not happening. We were told on the last visit that pharmacy had input to the wards, that they attended MDT meetings and carried out annual audits. We were told this time that pharmacy continued to have input to MDT meetings. Our view was that annual audits were

insufficient to identify any specific treatment issues and that a more robust audit and monitoring system was required, as whatever mechanisms had been put in place, had not effected change.

The Commission made a specific recommendation following the last visit regarding patients treatment forms and following this visit, identified further concerns about the lack of improvements made, therefore the Commission will follow up on this matter and request an urgent meeting with senior managers of NHS Grampian. We followed up the issues with patients' treatment on the day and will continue to follow those up with the designated RMO for each patient.

We advised managers that all patients who had received treatment out with the authority of the Mental Health Act should receive written notification, should be given information about their right to legal advice and advocacy support, as well as informing their named person and mental health officer. The Commission would normally consult with advocacy services prior to a visit however, as this visit was unannounced contact will be made as a follow up action.

Some patients we met with during our visit had a good understanding of their rights and of the detention process and others we spoke with were unsure. Any patient that received treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Some patients told us that they had the support of an advocate, whilst others told us that they had nominated a named person and we saw recording of this in the patient file.

Each ward had a display board in the office that provided an overview of all patients in the ward that recorded the patients' legal status. We saw 'AWI' had been recorded beside a few of the patient names across all wards and therefore we had a further discussion with the SCN's regarding this. We found that where AWI was recorded this was often referred to as a section 47 treatment certificate of the Adults with Incapacity (Scotland) Act 2000 that was 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 (Scotland) 2000 legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We saw where patients had a completed s47 certificate in place however, there was a variation in the standard of the completion. We found some certificates that were out-of-date, so it was unclear if the patient continued to lack capacity about medical treatment and not all had a treatment plan in place.

We followed up on one patient in Dunnottar Ward to gain clarity what the recording of 'AWI' meant. We were told that a guardianship order was in place and that the local authority had been appointed by the courts, however this was not the case. We raised the concerns about the recording of 'AWI' on patient records with managers as we consider that this could lead to confusion amongst clinical staff and create a lack of clarity.

The Commission has published an advice note guide about section 47 certificates. It is designed to help nurses and other clinical staff understand about section 47 treatment certificates and what these are, for people with mental ill health, dementia or learning

disability, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2021-10/Scope-Limitations-S47_advice2021.pdf

Recommendation 6:
Managers are required to ensure that all patients' individual treatments are discussed as part of the weekly MDT meeting, ensuring all relevant treatments are authorised under the Mental Health Act.

Recommendation 7:
Managers must ensure that there is a robust process in place to ensure mental health treatment certificates cover all patients' medication as outlined in the Mental Health Act and that there are regular audits in place.

Recommendation 8:
Managers should ensure that copies all treatment forms, T2/3, section 47 certificate, treatment plan, and covert medication pathway be stored with the drug prescription sheet.

Recommendation 9:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with AWIA code of practice for medical practitioners and that these are regularly audited and are discussed and reviewed at the weekly MDT meetings.

Rights and restrictions

The main door to each ward was locked and we were told this was due to the level of risk identified in the patient group. There was no notice on any of the wards and no locked door policy on display. The staff told us that the risk would be significant should the door be left open. Managers told us that the door to the wards had been locked since the ligature reduction work was completed in the wards. Where patients were detained under the Mental Health Act this provided the authority to restrict patients from leaving the ward, however where patients are in hospital on an informal basis, patients are required to know their rights and should be able to come and go from the ward when they so wish.

Some patients told us that they were unsure about their rights, where some patients had a good understanding. Some patients told us that they were happy that the door was locked as they did not want just anyone coming into the ward, invading their privacy. We saw letters that patients who had been detained under the Mental Health Act had received, which provided detailed information about their rights. We suggested to the staff that patient rights should be explained and discussed throughout each patient's journey, as at the time of detention a patient may be too unwell to understand and act upon those rights. The advocacy service continued to visit the wards and support patients. Patients mentioned their contact with the advocacy service and this was reflected in the patients' records.

Sections 281 to 286 of the Mental Health Act provides 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 specified person restrictions were in place under the Mental Health Act, the documentation in place varied. We found issues related to the documentation

in Huntly and Fraser Wards. We found that reasoned opinions were not all in place where they should be. Specified person status was not discussed at the MDT meeting and we could see no evidence of ongoing review. Staff told us that some patients were subject to specified person legislation, however when we reviewed paperwork this had either expired or the appropriate documentation was missing.

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

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 saw some advance statements in patient files, along with recorded discussions between patient and nursing staff and saw entries in the records documenting where a patient did not wish to make an advance statement. We had a further discussion with managers about advance statements and how the use of advocacy services could support patients with this. We saw that the wards had information displayed on the walls in promoting patient rights.

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

Recommendation 10:
Managers must ensure that a locked door policy is on display in each of the wards.

Recommendation11:
Managers should ensure that for those patients where specified persons procedures are implemented that the relevant paperwork, including reasoned opinion is completed, reviewed and audited.

Activity and occupation

The wards had input from OTs that provided group and one-to-one activities for the patients. Some patients that we spoke with across the wards were able to tell us about their activities, such as cooking classes, lunch groups, art group and the gym. One patient in Huntly Ward told us that the cooking classes enabled them to maintain their skills whilst in hospital and another patient told us that their attendance at the gym helped with improving their mental wellbeing. We were told that nursing staff sometimes carry out ward-based activities however, this depended on clinical demand.

As patients were at different stages of their recovery, some patients were more confined to the wards, whereas other had passes from the ward to the community as part of their discharge planning. We heard from many patients that they were bored, particularly in the evenings, as there was not much to do. The wards had a television in the main sitting/dining area, where we saw some patients reading, drawing and doing puzzles on our visit.

Recording of activities was limited in patients' files and in care plans and we gained a sense that patients wanted more to do in order to keep themselves occupied.

We were pleased to hear about the three new health care support worker posts that had been advertised with the aim of providing structured group and one-to-one therapeutic activities across the wards. We look forward to hearing about this on our next visit, along with evidence recording the benefit to the patient.

The physical environment

The three wards compromised of single en-suite rooms and dormitories. We were told that the single bedrooms were largely for individuals who were acutely unwell, who required continuous intervention or for a variety of reasons, were unable to manage sleeping in a shared dormitory. We were told that patients who had physical health needs may also be allocated a single room, depending on need. Some patients told us that they found it difficult to share a dormitory due to a lack of privacy and another patient told us that due to the lack of space in the ward, private discussion with staff were difficult. One patient told us about a time when the doctor met with them in the dormitory, meaning everyone else was able to hear the discussion, as there were only curtains around the bed.

The environments were bright, clean and each ward had a dining area, a separate TV area and a quiet lounge. Due to the increase in patient admissions, patients and staff told us that the lack of space was at times an issue, one patient commenting "people shift from room to room a lot".

Patients' feedback in relation to the environment varied across the wards. Some patients told us that they felt safe in the ward, whereas some patients told us they often felt scared and unsafe. This was a particular theme from the female patients we spoke with across the three wards. Patients told us about their experience of sharing dormitories and how it was difficult, depending on who else they were sharing with. Some patients told us that they did not mind sharing and how they enjoyed the company and support of others. A high number of patients reported to us that the noise levels were difficult to deal with, and some patients told us that they felt more mentally unwell being admitted into the busy, chaotic environment. A few patients in Dunnottar Ward told us that they found the environment distressing and it was difficult when the response alarms went off. Some patients in Dunnottar Ward also commented on the ward being cold, whilst some patients in Huntly Ward told us the ward was too hot.

Any other comments

We had heard about patients who were identified as delayed discharge, however the Commission is aware from previous visits that the health board and HSCP also have a delayed transfer of care list, where patients who were medically fit for discharge could also be placed on this list. We are continuing to follow this up with senior managers of the health board, as there had been some concerns about these lists and the indifferences.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is a regular audit process in place in order to improve the quality of care plans and ensure that they reflect and detail interventions which support patients' movement towards their care goals, along with regular reviews, summative evaluations, and evidence of patients' and carers' involvement.

Recommendation 2:
Managers should ensure that nursing entries in patient records comply with the Nursing and Midwifery Council Code, Professional Standards of Practice, and Behaviour for Nurses, Midwives and Nursing Associates.

Recommendation 3:
Managers must ensure that all risk assessments are regularly reviewed, updated, and discussed within the MDT meeting to ensure they accurately reflect the patients' assessed risk and that an agreed risk management plan is formulated.

Recommendation 4:
Managers should develop a mechanism to ensure patients and/or relatives are able to have their views considered at the MDT meeting and that feedback is given to patients and/or relatives following the meeting.

Recommendation 5:
Managers should regularly audit the MDT record documentation to ensure that it clearly documents attendance, discussions, decision taken and record patients' and/or relatives' participation.

Recommendation 6:
Managers are required to ensure that all patients' individual treatments are discussed as part of the weekly MDT meeting, ensuring all relevant treatments are authorised under the Mental Health Act.

Recommendation 7:
Managers must ensure that there is a robust process in place to ensure mental health treatment certificates cover all patients' medication as outlined in the Mental Health Act and that there are regular audits in place.

Recommendation 8:
Managers should ensure that copies all treatment forms, T2/3, section 47 certificate, treatment plan, and covert medication pathway be stored with the drug prescription sheet.

Recommendation 9:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with AWIA code of practice for medical practitioners and that these are regularly audited and are discussed and reviewed at the weekly MDT meetings.

Recommendation 10:
Managers must ensure that a locked door policy is on display in each of the wards.

Recommendation11:
Managers should ensure that for those patients where specified persons procedures are implemented that the relevant paperwork, including reasoned opinion is completed, reviewed and audited.

Service response to recommendations

The Commission requires a response to these recommendations 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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