Mental Welfare Commission for Scotland

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

Date of visit: 18 April 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 announced visit was carried out face-to-face.

Drum Ward was a 20-bedded, mixed-sex admissions ward for older adults who had a diagnosis of a functional mental illness.

The ward was decanted from Davan Ward in 2019, as part of the ligature reduction programme of works that had been scheduled across the Royal Cornhill Hospital site. Senior managers in NHS Grampian had updated the Commission about the planned ward moves, and of the ongoing refurbishment works. We had been informed that the refurbishment works had been completed and that the two older adult, newly refurbished wards were due to open in September 2021, however those wards were unable to open due to issues with water quality. Senior managers of NHS Grampian had kept the Commission updated regarding those issues and of ongoing environmental challenges in Drum Ward.

Drum Ward had not had any of the refurbishment work carried out and we were told that due to ligature risks in this ward, some patients had to be admitted to another ward, out with their catchment area, in order to deliver safe patient care.

The senior charge nurse (SCN) told us that the ward mainly admitted individuals from the Aberdeenshire area, however due to the level of activity across the in-patient wards, Drum Ward also admitted individuals with dementia and those from Aberdeen city.

We last visited the older adult functional wards in Royal Cornhill Hospital as part of the Commissions themed visit to older people's functional mental health wards in 2019.

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 report that was published in April 2020.The Commission had also received calls to the duty advice line from patients and carers expressing concerns about the current environment in Drum Ward. We wanted to find out what impact the environment had on patient care, treatment and recovery.

Who we met with

Prior to the visit, we held a virtual meeting with the SCN and in-patient service manager.

On the day of the visit, we spoke with the SCN, ward-based nursing staff and occupational therapy (OT). At the end of the visit, we met with the clinical nurse manager, clinical lead for older adults, in-patient service manager and interim lead nurse.

We met with five patients, reviewed the notes of seven patients and met with two carers.

Commission visitors

Tracey Ferguson, social work officer
Gillian Gibson, nursing officer
Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

The ward had a mix of patients with a functional mental illness and dementia and we introduced ourselves to most of the patients and chatted to them throughout the day. We were not able to have in-depth conversations with all the patients in the ward, due to the progression of their illness, however from our observations, all the patients appeared settled in the ward and where there was evidence of stress/distress behaviours, we saw nursing staff responding quickly and in a supportive manner.

Feedback from patients and carers was mostly good. Patients described staff as “nice”, “friendly” and “approachable”. Some patients told us that the staff were always busy and therefore this sometimes prevented them from seeking support. Most patients knew who their named nurse was and were able to tell us about their involvement in their care and treatment, however, this was not the same for all patients. Some patients told us that they did not feel involved or consulted about their care and treatment.

One carer we spoke with described staff as “excellent” and “very approachable”. Another carer we spoke with told us about issues with laundry and how items of clothing had not been returned. Carers told us that they felt the ward was welcoming and that they could visit most times. One carer told us that they felt the ward was not suitable for people with dementia and that patients with dementia and a functional illness should not be in the same ward together. We heard from some patients and a carer that there was not always an opportunity to meet with a doctor, therefore this left them unaware as to what was happening with plans for discharge.

Where patients had been detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act), we found that the patients had been provided with information about their rights and had access to advocacy services, which was positive. Some patients told us about the support they had received in order to appeal their detention and had knowledge about the role of the Mental Health Tribunal and the role of the mental health officer.

Care planning and documentation

On this visit, we saw some evidence of detailed care plans, however this was not consistent across the files we had reviewed. Recordings noted in a number of care plans was more generic, for example we found the files to contain phrases such as ‘monitor mental state’ or ‘fully assess mental state’, with little context around what staff were observing. Where some patients had stress/distress behaviours, there was no specific detail in the plans as to how staff supported the patient.

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 evaluation and patient goals were limited. We found that not all care plans were person-centred and holistic, in covering all patients physical and mental health needs. We found that the nursing continuation notes made reference to the patient care plan activity, which was good, however they lacked detail.

We wanted to find out about patient and carer involvement in care and treatment. All the care plans we reviewed, recorded 'patient unable to sign due to mental state', however during our visit, we engaged in conversations with patients about their care and treatment and most patients appeared informed about this. Some patients that we had spoken with had not heard of the term 'care plan'. It was unclear if patients' involvement in their care planning was re-visited at various stages of their recovery journey, and we found no recordings in files to suggest that the care plans had been shared with relatives and/or legal proxies or of their involvement in developing such plans.

The ward staff recorded information in the NHS Grampian admission booklet, and we were aware from other local visits that this booklet is being reviewed as staff and managers had found that the documentation was insufficient. We had been told that there was a short life working group that was reviewing all documentation and we were told that NHS Grampian was moving to an electronic system in the near future; we will look for updates from managers about the review of the documentation.

We asked managers about the audit processes, however we were told that there was no active audit process in place.

Where we found evidence of one-to-one discussions in patients' files, we found that some entries were detailed, however there was inconsistent recording of this. We found some patients had regular sessions and were able to tell us about the benefits of these, however we found a lack of recording in some patients' files. It was not clearly evidenced in any of the records if the patient had been offered one-to-one contact and whether this had been refused or if it had not been offered.

In the patients' files there were detailed nursing assessments that had been completed at the point of admission, along with risk assessments and risk management plans.

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 of the patients' notes in place, which includes ensuring care plans are person-centred, reflect and detail interventions that support patients towards their care goals, are regularly reviewed, contain summative evaluations, and evidence patient and carer involvement.

Multidisciplinary team (MDT)

We were told that there were five consultant psychiatrists who covered the ward and there were five separate MDT meetings that took place weekly.

As expected, the ward had good input, from a wide range of professionals such as a consultant psychiatrist, psychology, OT and the GP, who provided input regarding patients' physical care. We found that there was good attention to the link between physical and mental health care in the patient records. Staff told us that patients had good access to allied health

professionals, such as dietetics and physiotherapy, which we saw on the day of our visit. The SCN told us that physiotherapy staff attended the ward most days to support patients with mobility assessments and provided patients with daily exercise groups.

We had been made aware that OT was undertaking a review, as the service had been experiencing issues around recruitment and retention. However, the SCN told us that the input from OT had continued throughout the Covid-19 pandemic and that the ward still receives regular input, which was positive.

We were told that there was an MDT document that was completed at the weekly MDT meeting. The template appeared to be comprehensive in that it recorded attendees, and had a variety of sections for completion, that included patients' progress/updates, treatment certificates, patients' views/requests and legal status. On reviewing patients' files, we frequently found only first names recorded of the attendees and the meetings mainly consisted of the nurse and doctor. We found that the record lacked detail regarding patients' weekly progress and therefore it was difficult to determine what progress had been made.

We asked about patient participation or involvement as part of the weekly review at the MDT meeting. We were informed that patients tend not to be invited, and we noted that no patients or family appeared to have attended the meeting; it was difficult to know when feedback happened following the MDT meeting, as there was lack of recording and no process in place to state that feedback had been given. A few patients told us that they met regularly with their consultant, which had provided them with an opportunity to feel involved in their care and treatment. Other patients told us that they had not met with their consultant. We asked about the 'boarding' patients and were told that the consultant attached to each patient's geographical area would remain the patient's responsible medical officer (RMO) wherever they were boarding to. We saw evidence of this on reviewing patients' files.

We saw a section on the MDT record for patient views, however the majority we reviewed were blank. We did find some examples where patient views had been sought in advance of the meeting, and patients told us of the meeting, however from reviewing the records we found that patients' views were not always discussed. This concerned us, as there appeared to be an inconsistent approach to patient involvement or opportunities to be involved in the ongoing discussions about their care and treatment as part of their recovery journey.

We asked the SCN about patients who were recorded as delayed discharge. We were told that there were a few patients who were delayed and that there were a few patients on the delayed transfer of care list. Further discussions around these lists provided no clarity, which was consistent with what we found on other recent local visits. We were aware that NHS Grampian were operating two lists. We will continue to have discussions with senior managers regarding these lists, in an effort to understand how they are operating.

We had a further discussion about one patient's delay, as we had noted from reviewing the file that the patient had been referred to social work only after a decision had been made regarding their fitness for discharge. We asked about social work attendance at the MDT and delayed discharge meetings that were taking place; we were told that this was inconsistent across Aberdeen City and Aberdeenshire. We were concerned about the timing of the referral to social work and therefore had further discussion with the SCN about this.

Recommendation 2:
Managers should ensure that the MDT record clearly records attendance, discussions, actions, and incorporates patients' and relatives' views. There also should be a mechanism to provide feedback to patients following the meeting.

Use of mental health and incapacity legislation

On the day of our visit, 11 patients in the ward were detained under the Mental Health Act.

Part 16 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. Authorising treatment forms such as T2 or T3 are required to be in place and we found that where a certificate was required, that there was one in place that corresponded with the prescribed psychotropic medication.

For patients who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), we saw copies of the legal order in place. However, we brought one case to the SCN's attention, as the ward had only received the front sheet of the power of attorney (POA) document. We had a further discussion with the SCN about this and were told that the relative had been asked to provide the other part of the document. Where a POA was in place, it was difficult to know if the POA was activated or not as there was no recording in the patient's file.

The Commission had published the *Authority to discharge* report in May 2021, where concerns had been raised about moves from hospital to care homes for people who lacked capacity, and also found there was lack of understanding by professionals around the law, including misunderstandings about POA. The Commission is continuing to follow up on the recommendations with health boards and health and social care partnerships (HSCPs). The report can be found here: AuthorityToDischarge-Report_May2021.pdf

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan under section 47 of the Adults with Incapacity (Scotland) 2000 Act (AWI) 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, who has relevant powers and record this on the form. We found some that were very detailed and completed in accordance with the adults with incapacity act code of practice for medical practitioners, however we found one certificate that was not satisfactory and brought this to the attention of the SCN.

On reviewing patients' notes, we were pleased to see the legal checklist form that staff used to record specific legal orders that patients were subject to under AWI Act legislation. However, we found some entries that were unclear as to the particular section of the AWI Act that the patient was subject to. We found a few entries that simply recorded "AWIA in place". We brought this to the attention of the SCN on the day, as we considered this lack of detail and clarity could lead to confusion amongst clinical staff. The ward had a display board in the office that provided an overview of all patients in the ward and recorded their legal status. We saw 'AWI' had been recorded beside a few of the patient names across wards and had a

further discussion with the SCN regarding this. We found that where AWI was recorded on the board, this referred to a s47 treatment certificate of the AWI Act being in place. We found that treatment forms were not kept together and had difficulty locating them all; we discussed this with the SCN.

Recommendation 3:
Managers should ensure that copies all treatment forms; T2 and T3 certificates, section 47 certificates, associated treatment plans, and covert medication pathways are stored with the drug prescription sheet**.**

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction be applied. Where specified person restrictions under the Mental Health Act were in place, the documentation was in order, with the exception of one patient. This was brought to the SCN's attention.

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

The door to the ward was locked and we saw individual risk assessments that identified patients, who due to their vulnerability and progression of their illness, would be at risk if the door were left unlocked. Some patients told us that they felt safe in the ward and this was due to the door being locked. NHS Grampian have a locked door policy available.

The ward had good links with advocacy service, who were based in the hospital and we were able to see involvement of advocacy services when reviewing patient files. Patients also told us about the support from advocacy at meetings and at mental health tribunals. We heard about the community meetings that advocacy set up regularly on the ward, which was positive.

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

We looked for evidence of activity planning in patient files and had hoped to see activities that were linked to individual goals that were then evaluated. Although we found some reference to activities, there was variation and generalisation in what was recorded, as opposed to individualised activity plans. There was limited recording of activities in patients' files and in care planning that lead us to understand that patients were likely to have wanted to do more to keep them occupied.

We heard that OT provided activities to the ward however, there was no visual planner in place for patients to know when and what activities was due to take place. The OT told us that she would often decide with patients on the day about the activities they may want to do.

Physiotherapy staff provided daily exercises to patients and their planner was clearly displayed on the wall in the ward. We saw activities happening on the day of our visit and patients appeared to enjoy these. Some patients were able to tell us about the activities they enjoyed and others told us that there was not enough to do, which led to boredom.

Therapeutic activities are important to support patients with their stress/distress symptoms and we heard from staff about the benefit and focus of activities. However, we also heard that demands of nursing tasks could impact on the delivery of activities. All activities took place between the days of Monday to Friday, with no dedicated activities on weekends. The SCN told us that the ward was in the process of recruiting an activity coordinator and we look forward to getting an update about this on our next visit.

The physical environment

The ward was situated on the first floor of the building, and had no access to a garden. The ward had a mixture of shared dormitories and single bedrooms. Each dormitory had access to a shower room and toilet. Some patients told us that they did not mind sharing with others and others told us that they enjoyed having their own rooms, however did not like when other patients, who had dementia, tended to walk into their rooms and invade their private space.

Some patients told us that the ward was not suitable for older people, as the showers did not have level access. One patient told us about tiles falling off the walls in the shared dormitory toilet that meant the toilet facilities were out of action for a few weeks. This resulted in patients having to walk further to another shared toilet during the day and night.

We heard from patients and staff about the ward being too hot at times and the lack of fresh air into the ward as the windows did not open. This was evident on our day of the visit.

There was a separate dining area along with a sitting area, where the activities took place. The ward had a quiet room for visitors and another room off the ward was available for visitors. There was a small kitchen room that we were told patients had access to make tea/coffee, however some patients told us that this was often locked.

The SCN told us that she had to vacate her office due to water coming in from the ceiling. We heard that some works were being carried out, however these were not always completed promptly. The ward had many ligature points and no work had been done to reduce those identified risks. We heard from staff and senior managers about the environmental impact on patient and staff safety. We heard about the staff's disappointment and frustration at not being able to move to the newly refurbished ward, however we also heard that the staff group had continued to work together as a team, supporting each other in keeping morale high, in order to provide good quality of care to patients in the current setting. We heard from the SCN that there had been no issues with staff retention, which was positive.

We would expect all wards to provide a therapeutic environment that includes sufficient living space, adequate lighting, a stimulating and enabling indoor and outdoor environment and to be in a satisfactory state of repair. There should be adequate space to uphold the privacy and dignity of patients. Access to an outside space is essential, due to the therapeutic benefit for patients. This is particularly important for those who are not able to leave the ward.

We have continued to receive updates regarding the potential moves to the newly refurbished wards, and will continue to link in with senior managers regarding this.

Any other comments

We are aware that there may be times when individuals with dementia are admitted to a ward for patients with a functional mental illness. This may be appropriate when patients with dementia require an assessment and treatment for a concurrent functional mental illness, or are early in the process of diagnosis, when it is not clear if the patient has a functional illness or dementia. However, in general the Commission does not think that these types of mixed wards meet the needs of either patient groups, as we are aware, where wards are mixed, nurses often describe difficulties and unfortunately, this is what we found on this visit. These views were also echoed by some patients and a carer.

Not only did this ward have patients with a functional mental illness and dementia, but also had patients boarding from other wards. We were concerned about this and discussed this further with senior managers on the day of the visit. We were informed that this is all being looked at as part of the older peoples' transformation project, and were told when the newly refurbished wards open, it is hoped that those issue will be addressed. Therefore, we will write to senior managers to request an update about the outcome of the review, along with an update on developments regarding the opening of the new wards.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is a regular audit process of the patients' notes in place, which includes ensuring care plans are person-centred, reflect and detail interventions that support patients towards their care goals, are regularly reviewed, contain summative evaluations, and evidence patient and carer involvement.

Recommendation 2:
Managers should ensure that the MDT record clearly records attendance, discussions, actions, and incorporates patient and relative views. There also should be a mechanism to provide feedback to patients following the meeting.

Recommendation 3:
Managers should ensure that copies all treatment forms; T2 and T3 certificates, section 47 certificates, associated treatment plans, and covert medication pathways are stored with the drug prescription sheet**.**

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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