Mental Welfare Commission for Scotland

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

Date of visit: 11 May 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 visit was carried out face-to-face.

The learning disability service consisted of two wards, Strathbeg and Loirston, which were both located in the main site of Royal Cornhill Hospital.

Strathbeg Ward provided admission for adults with a learning disability who presented with behaviour that was harmful to themselves or others, and that required close supervision in a secure environment. Some patients admitted to this ward had come via the forensic pathway, and had been assessed as requiring a lower level of security. The ward covered the northeast area of Grampian, although also admitted patients from across Grampian, Highland, Western Isles and Orkney. This eight-bedded ward admitted male patients only. On the day of our visit, there were six patients, with one patient on extended pass to the community.

Loirston Ward was an admission ward that provided assessment and treatment for adults with a learning disability, who had a psychiatric illness and/or presented with behaviour that was complex to manage. Loirston Ward had eight admission beds, and on the day of our visit, the ward had four patients; however, none of the patients had a learning disability. The four patients were boarding from the older adult and adult acute wards.

Managers told us that between the two wards, the current capacity continued to be capped at a maximum of 13 patients.

We last visited this service on 28 April 2022 and made recommendations in relation to section 47 adults with incapacity certificates and ward maintenance. We received a response from the service that included an action plan as to how the service planned to make those improvements. We had continued to follow up on a previous recommendation that was made following a visit in 2019, where both wards were situated at Elmwood Hospital and a recommendation was made that the service needed to devise a seclusion policy. We continued to be concerned that the service had not yet completed this action, and there remains no seclusion policy in place.

On the day of this visit, we wanted to follow up on the previous recommendations and speak with patients, relatives and staff. We had continued to follow up with senior managers about the environment since the wards had moved from Elmwood Hospital in 2020, as both ward environments were not designed specifically for individuals with a learning disability and/or complex sensory needs. We had heard that a functionality assessment of both wards had been completed however, on continued follow up with the senior manager and the service, this report had not been seen and therefore a copy of the outcome of the assessment was unknown. This was a concern, as no progress had been made following this assessment, and staff who had been involved in the assessment had identified areas where improvement was needed for patients and staff.

We also wanted to follow up on patients whose discharge from hospital had been delayed, given that the service had some patients who had been delayed in hospital for a significant period of time.

Who we met with

Prior to the visit we met with the learning disability lead nurse, consultant psychiatrist, senior charge nurses (SCN's) of both wards, and the occupational therapist (OT) via video call.

We spoke with three patients in Loirston Ward and spoke with and reviewed the care and treatment of four patients in Strathbeg Ward. We also spoke with two relatives.

On the day of the visit, we spoke with a range of nursing/ward staff and managers. We also liaised with the local advocacy service.

Commission visitors

Tracey Ferguson, social work officer

Anne Buchanan, nursing officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

Feedback from patients in Strathbeg Ward was mostly good and some patients describing staff as “approachable” and “nice”. Patients that we spoke with were generally happy with their level of care and treatment and were able to tell us about this during the conversations. Patients seemed to know who their named nurse was and who they would go to if they needed support.

A few of the patients in Strathbeg Ward told us that they felt safe in the ward, however at times the ward could be noisy, which patients told us they found difficult. One patient told us that when the ward was busy, they found this stressful, as there were not enough quiet spaces to retreat to. One patient told us that their move to the ward had enabled them to have more access to the community, and that staff supported this in a positive manner.

Patients were able to tell us about their weekly planners, of their current care and treatment and input from professionals such as occupational therapy (OT) and psychology. Patients told us about the regular meetings with their consultant psychiatrist and of their involvement in care programme approach (CPA) meetings. The CPA framework provided a multi-agency approach to patients who had complex needs and required a more intensive support. This approach provided a robust framework for managing patients care, particular in relation to the management of risk. One relative told us that they had noticed improvements in their relative’s care since they had moved to the less secure environment, and that the team were supportive and communication had been good. Another relative told us that they did not feel the communication was always good, but knew who to contact to discuss their relative’s care and treatment.

Some patients told us of their frustration with the lack of progress about their discharge to the community, and how they felt it was unfair that they were still in hospital.

Most patients in Loirston Ward had recently been admitted to the ward and told us about their experience coming from another specialist area. All patients told us that they were happier in Loirston Ward, as it provided a more peaceful environment and the staff made them feel very welcome. One patient described Loirston as “paradise” in comparison to the adult acute ward. Two of the patients who were boarding from the adult acute wards told us that they had no choice but to move, as the alternative was discharge to community, and both patients were homeless; both told us that they were not ready to be discharged.

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

Both wards had a mix of mental health and learning disability nurses and both SCN’s were registered learning disability nurses. We were told that there were some staffing vacancies across the service and that there continued to be a recruitment drive to fill vacant posts. Staffing challenges were acknowledged by managers who were continuing to be proactive in their efforts to recruit to posts. We recognised that this was an issue nationally, and specifically with learning disability nurses. We heard that where possible, the wards continued

to use regular bank staff to promote consistency and relationship building, in order to enhance the quality of care provided to the patients.

We were told that the service had developed an induction pack for new staff who were not specifically learning disability training in order to enhance the knowledge and skills of the staff team. Some of the topics included autism, positive behavioural support framework and health equality and we were told that new members of the multidisciplinary team had also found this beneficial.

Care planning and documentation

On reviewing patient notes, we found detailed nursing assessments that had been updated for those patients who had been in the ward for some time. Detailed risk assessments and risk management plans were in place, and we saw that those documents had been regularly reviewed. We found one risk assessment that required to be updated and discussed this further with SCN, who told us that there was a date to update the specific risk assessment document as part of the patient's discharge planning.

Care plans were detailed, person-centred, and covered a wide range of holistic needs with evidence of a multi-disciplinary approach to patients' care and treatment. We saw regular reviews of the care plans, with recorded evaluation. We found care plans that had been devised as 'easy read' or were in pictorial format, to support patients' involvement and understanding. We saw recorded evidence where patients were involved in their care planning. However, there was one file where this was unclear, as none of the care plans had been signed by the patient and there was no record if the patient agreed or disagreed with their treatment plan. We suggested that an entry in the file/document would support this.

We found evidence of annual health checks being carried out and saw clear evidence of physical health care and monitoring. The wards continued to use the Health Equalities framework (HEF), an outcomes framework that measured health outcomes for people with learning disabilities. Staff were continuing to complete the HEF at specific points of a patient's journey.

Multidisciplinary team (MDT)

The wards have comprehensive input from a MDT into patients care and treatment, working effectively in addressing patients holistic needs, whilst managing risk.

From reviewing the patients' files, we saw that MDT meetings took place every week and we found that there were recorded minutes of these meetings, with noted actions and outcomes. All patients in Strathbeg Ward continued to be managed using CPA. This provided a robust framework for managing patient care, particularly in relation to the management of risk. Patients did not always attend the weekly meeting, but had an opportunity to contribute; the consultant psychiatrist told us that he met with patients before and after meetings. Most meetings were happening via video link, and we were told that patients, welfare guardians, social workers and advocates, also had option to attend in person, where appropriate. The service had found that by using methods of virtual meetings, there had been a greater attendance at those meetings, particularly where patients' home areas were out with NHS Grampian. Patients continued to attend their CPA meeting and we reviewed the minutes of

those meetings and found that they were detailed, with recorded actions and outcomes. Some patients had the support of their advocate, which enabled patients to contribute their views and experiences into the meeting, in a supported and positive manner.

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

We were told that all the patients in Loirston Ward were boarding from other areas due to the lack of bed provision, driven by the clinical demand for admissions from the community. Managers told us that they do try and transfer patients back to their geographical ward as soon as possible, if possible, and that the consultant would remain each patient's responsible medical officer (RMO), wherever they are boarding to. However, we had heard on previous visits from patients where this had not been the case and some patients told us that they had not seen their consultant. We had also heard that it was difficult and time consuming for consultants to review patients care across multiple hospital wards. However, we had been told the hospital had a boarding protocol in place and that managers were continuing to review that this was being adhered to.

We had continued to follow up and review the discharge plans for patients where there had been significant delays in hospital. Since our last visit, we had been pleased to hear about some of those patients with significant and complex needs, where joint working between the in-patient and community staff had made the transition successful.

We were told there were three patients in Strathbeg Ward where there had been delays in progressing discharge to the community. The lack of progress had been mainly around no available suitable accommodation in the community. We discussed each patient's case on the day of our visit and we will continue to follow up on those individual cases with the RMO and with the health and social care partnership (HSCP).

Care records

Patients' notes were in paper format, and files were organised with separated sections for information and were easy to navigate. We had continued to hear about the plans for NHS Grampian to move to a new electronic system in the near future. We were told that there were ongoing pilot sites testing the system across the hospital. However, there was no planned date for this to be rolled out to the learning disability service yet.

We were aware that many of the patients in Strathbeg Ward had been in the ward for a long period of time, and there was a lot of detailed information in the files providing a good background history. We had discussed this with the lead nurse and we suggested to managers that they need to ensure that the new electronic system will fully meet their service needs and lend itself to robust and detailed recording.

Use of mental health and incapacity legislation

On the day of our visit, six patients in Strathbeg Ward and one patient in Loirston Ward were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) or Criminal Procedure (Scotland) Act 1995.

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

Paperwork relating to treatment under part 16 (s235-248) of the Mental Health Act was in order. The authorising treatment forms (T3) completed by the RMO that recorded non-consent, were available. We had a further discussion with the RMO regarding one T2 certificate that was in place.

The ward had a Mental Health Act checklist in each patient's file which was informative, regularly updated and reflected each patient's legal status.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; they are known as a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

We wanted to follow up on the recommendation that was made on the previous visit with regards to section 47 certificates. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (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. We saw where a patient had a completed section 47 certificate in place, and there was also a completed treatment plan. There was one accompanying treatment plan that detailed the same treatment that was being provided under Part 16 of the Mental Health Act, however there was a T3 certificate already in place which authorised this treatment. We suggested to managers that the treatment plan would benefit from a review in order to be more personalised towards the patient's treatment for physical health care. We also had a discussion with the RMO about another patient where a welfare guardian had been appointed via the courts and a power was in place to make decisions around the patient's medical treatment. The Commission's view was that a section 47 certificate along with a treatment plan was required to be in place for this patient. The RMO agreed to follow this up.

For patients who had a legal proxy appointed under the AWI Act, we saw copies of the legal order in the files.

Rights and restrictions

Ward staff and advocacy continued to support patients with their rights and we saw evidence of this in patients' files, where information was accessible and in pictorial format. Some patients we spoke with were able to tell us about their rights and how they had been supported with legal representation and had awareness of the Mental Health Tribunal for Scotland (MHTS).

Both wards were locked, and there was a locked door policy in place, that was balanced with the level of risk being managed, particularly in Strathbeg Ward. For those patients who were boarding in Loirston Ward and were not subject to detention under the Mental Health Act, we wanted to find out if the locked door had any impact. The SCN told us that the patients were informed about the locked door on admission, and informed how to gain access to and from the ward. Patients told us that they had no issues with access to and from the ward and that staff had been helpful when they had wanted to go off the ward.

Each patient in Strathbeg Ward had their own detailed escort plan, as we accept there were a number of patients who required their time away from the ward to be supervised. We were pleased to see escort plans that were reviewed regularly by the MDT and amended where necessary.

Section 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 we were told that restrictions had been placed on a patient, we found the appropriate documentation in the patient's file which authorised this, with the exception of one patient, so we brought this to the attention of the SCN.

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

We wanted to follow up on a recommendation we made regarding the need for a seclusion policy from a previous visit which took place in March 2021. Seclusion was being applied to a patient when the ward was previously in Elmwood Hospital and although there was appropriate documentation in place, there was no overarching policy for the use of such restrictions. We had also been told that the plan was to develop an intensive support suite in part of Loirston Ward, therefore a seclusion policy that provided clear guidance for the use of the suite and service would be required. The Commission believe that the service must ensure that seclusion is not applied until there is a seclusion policy in place.

We had been told that there was a service group looking at a policy, however we had continued to follow this up with senior managers and were concerned that there was still no policy in place. The lead nurse and clinical lead told us that they had linked in with other areas and will take this forward. The Commission will write to senior managers of NHS Grampian and request further updates.

Recommendation 1:
Senior managers must devise a seclusion policy and ensure this policy is implemented across the service.

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

The wards had dedicated OT input that provided assessment focused activities; that included group and one-to-one activities. The OT staff continued to carry out assessments as part of each patient's discharge planning, supporting their re-integration back to the community. In Strathbeg Ward we saw that each patient had a weekly planner in place and patients told us about their activities. We heard that most of the activities took place in the community or in the recovery resource centre that was based in Royal Cornhill Hospital. One patient told us about a recent music concert they attended and the service were in the process of planning other events. Another patient told us that they enjoy going out to play bowling, shopping, and to the cinema. Patients told us that they enjoyed being out in the community.

We noted that there was clear recording of activities that were taking place and that there was a regular review of these with patients. Both wards continued to have access to vehicles to support community activities.

Since moving to the main hospital, both wards had developed dedicated activity areas in the ward that included gym equipment, TVs/game consoles; Strathbeg Ward had a pool table.

The SCN in Loirston Ward told us of the plans to recruit an activity nurse and who would be specifically activity focussed. We look forward to getting an update on our next visit.

The physical environment

The two wards moved into the older adult wards when they moved from Elmwood Hospital to the main site at Royal Cornhill Hospital in April 2020. Bracken moved to Loirston Ward and Fern moved to Strathbeg Ward.

Both wards had some single rooms with en-suite toilet facilities and dormitories. Due to the patient group in Strathbeg Ward each patient had required their own private space therefore some patients had a whole dormitory to themselves, whereas others had a single room. We saw how the staff had adapted areas and rooms in the ward to best meet the needs of the patients. The SCN in Loirston Ward told us that depending on the needs of the patient, sharing a dormitory may not be appropriate.

Both wards had one shower room and one bathroom each for all patients. The bath in each ward was more appropriate for the older patient group that used to occupy the ward and had not been changed to meet the needs of people with learning disability, autism or complex needs, such as sensory needs. We heard from staff and patients that the lack of showering/bathroom facilities caused difficulties for patients who were having to wait to access those facilities. We heard that the water pressure had improved however, this was not consistent.

Each single room had floor to ceiling glass windows that looked out to the ward corridor, and we heard from patients that there was lack of privacy.

We heard about the heat in the wards from patients and staff, and the lack of fresh air, as the windows did not open.

Patients had no access to kitchen/laundry facilities on the ward. This reduced the opportunities for rehabilitation and for patients to maintain the skills that they had prior to admission, however we did hear that patients were being supported off-ward to use such facilities. On previous visits, we had heard staff were trying to make improvements to the ward environment for patients and to aid rehabilitation, however we appreciated there was only so much the staff team could do to better the environment.

There was ample seating/dining areas in both wards, and the wards were spacious. There was no signage around the wards to support patients with orientation.

Strathbeg Ward had access to a garden however, we were told that the fence blew down in October last year and patients had been unable to use since. We did hear that this was due to be fixed the following week, due to another ward moving location.

We raised concerns with senior managers regarding the environment as we felt it did not support the patient group and there have been no significant changes to improve the environment. We appreciate the attempts that staff had made to make the environment better for patients since the move, however if both wards continued to be occupied for their current purpose, then changes are required.

We had been previously told that a functionality assessment was undertaken for both wards not long after the service moved from Elmwood Hospital to Royal Cornhill Hospital. We had continued to ask for updates regarding the progress of this assessment, and the works that had been identified as a result of this.

Recommendation 2:
Senior managers must ensure that environmental assessments of both wards are undertaken as soon as possible in order to identify and plan works to improve the environment, so it meets the needs of individuals with a learning disability and/or autism.

Summary of recommendations

Recommendation 1:
Senior managers must devise a seclusion policy and ensure this policy is implemented across the service.

Recommendation 2:
Senior managers must ensure that environmental assessments of both wards are undertaken as soon as possible in order to identify and plan works to improve the environment, so it meets the needs of individuals with a learning disability and/or autism.

Service response to recommendation

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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