Mental Welfare Commission for Scotland

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

Date of visit: 12 December 2023

Where we visited

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

The ward can admit up to 10 people, and on the day of the visit, the ward was full. The senior charge nurse (SCN) had previously informed us on our visit in 2022, that the bed occupancy had been reduced to eights beds during the Covid-19 pandemic, however occupancy had continued to increase back up to 10 beds over the past two years and has been maintained at this level. Managers told us that the ward had continued to receive transfers from other speciality wards due to lack of bed availability, however the senior leadership teams had a 'daily huddle' to discuss suitability of bed capacity and transfers.

On the day of the visit, we were told that the ward had three people who were recorded as 'boarders', and that two of those had been boarding in Brodie Ward prior to our visit in 2022, having been transferred from acute wards.

We last visited this service in November 2022 and made a recommendation for the service to devise a protocol for individuals who were placed in a ward out with their speciality ward. On the day of this visit, we wanted to speak with individuals, relatives and staff and find out how the service was implementing our previous recommendation.

Who we met with

Prior to the visit, we held a virtual meeting with the senior charge nurse (SCN) and consultant psychiatrist. On the day of the visit, we spoke with the service manager, SCN, ward-based staff, the lead nurse and the nurse manager.

We introduced ourselves to most of the people in the ward, however, we had a more in-depth conversation with three individuals and reviewed the care notes of five. In addition to this, we made contact with the local advocacy service based in the hospital.

Commission visitors

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

Given the complexity of people's needs in Brodie Ward, we were aware that some individuals had been in the ward for a longer period than others, and presented with very complex physical and mental health needs, as well as limited verbal communication. The SCN and consultant psychiatrist told us about the progress of some individual discharges since our last visit, which was positive to hear, and of the progress that was being made with other individuals' discharge planning. Due to the complexities, we were told that finding suitable placements locally was a challenge. We heard that there was one individual who had been identified as 'delayed discharge'. The term delayed discharge is when an individual, who is clinically ready for discharge, continues to occupy a bed, usually because of delays in securing a placement in a more appropriate setting.

Individuals who we spoke with described staff as "nice", "supportive", "helpful and always there for you". Individuals told us about their time off the ward, and about their participation in activities, on and off the ward. We heard from a few individuals that they would like to do more activities, as sometimes they were bored. Where an individual expressed to us that they did not want to be in hospital, they were able to tell us about their rights and the supports they had in place from services, such as advocacy and legal representatives. A few individuals were able to tell us about the next stage in their discharge planning process and about their regular meetings with the doctor, however one individual told us that they did not see their doctor often.

From our observations, the ward had a relaxed atmosphere and where there was evidence of stress/distress behaviours, we saw nursing staff responding to the individual in a supportive manner. From speaking to the staff team, we got the sense that they knew the individuals well and were familiar with their care and treatment and the interventions that best met their needs; this was similar to what we found on last year's visit.

Nursing care plans and documentation

The care plans were in paper format, and we found it easy to navigate in individuals' files.

We were aware from other local visits carried out at the Royal Cornhill Hospital that there had been a short life working group devised to improve care planning processes and documentation across NHS Grampian. A pilot has been run of the new documentation, which had just been completed, and the new documentation had been rolled out to all wards, including Brodie.

On our previous visits to Brodie Ward, given the complexity of the individuals admitted, we found that there to be a good level of detail in care plans. On this visit, we reviewed files and saw the new care planning documentation had been put in place and we found those care plans detailed and person-centred. We found care plans that had been updated following the review process, however this was not consistent, as we found some care plans where there had been changes following the review process, but the care plan was not always updated. We saw some files where there was evidence of individual involvement in this process, along with some care plans where it had recorded that the individual was unable to sign. We are

aware that the care planning documentation roll out was still in early stages of implementation and that there had been a new audit tool devised to support improvement across these areas; we look forward to seeing progress on our future visits and will continue to liaise with the senior nursing teams.

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

The SCN told us that since our last visit, the daily nursing entries were now completed on the electronic system, TRAK. We found detailed information contained in regular one-to-one discussions with each individual's named nurse, which was meaningful, however, this was inconsistently completed across the files we reviewed. We had a discussion with the SCN about this and were told that the new audit tool that was being put in place should address this, leading to improvement in overall recording.

We saw some detailed 'Getting to Know You' documents in the files that gave a clear account of individual's history, outlining their likes, and dislikes. We noted that a few of these documents had been completed some time ago, and some of the information did not reflect the individual's current state. We advised the SCN that it would be beneficial for the named nurses to review those 'Getting to Know You' documents and update these where necessary. We found 'Do not attempt cardiopulmonary resuscitation' (DNACPR) documentation in individual files that was all in order.

We reviewed individual risk assessments and risk management plans that were in place, and although there was evidence of reviews happening, we found that this was not regularly taking place throughout the individual's journey. We found some assessments where the level of individual risk had changed, and the risk assessment and risk management plans had not been updated to reflect this change.

Recommendation 1:
Managers must ensure that all risk assessments are regularly reviewed, updated, and discussed within the MDT meeting to ensure they accurately reflect each individual's assessed risk and that an agreed risk management plan is formulated.

On reviewing the individual files, we saw evidence of good physical health care monitoring and where covert medication pathways were in place, we saw appropriate documentation, along with ongoing review, which was good.

Our covert medication guidance can be found here:
https://www.mwcscot.org.uk/sites/default/files/2022-05/CovertMedication-GoodPracticeGuide_2022.pdf

Multidisciplinary team (MDT)

We heard that the MDT meetings took place weekly and individuals could meet with the doctor before, or after, these meetings. The ward continued to have regular input from the GP to

assist with physical health matters and the GP was also part of the weekly MDT meetings. Pharmacy also continued to provide regular input to the MDT meeting.

We were told that the team had recently recruited to the vacant clinical psychologist post, which was positive, and that the plan was for the psychologist to attend the weekly MDT meeting.

We also found that where individuals required input from other healthcare professionals, and where this had been identified, it was discussed with the MDT and these services were accessed as part of each individual's care and treatment.

Managers told us that the current provision of occupational therapy (OT) input to the ward remained similar to what we found on last year's visit, in that OT did not attend the weekly MDT meetings however, continued to work with individuals following referral. The SCN told us that the MDT and individuals in the ward continued to have access to OT where it had been identified as part of an individual's care and treatment.

The MDT meeting record was held electronically and included a note of who attended the meeting, along with the actions and outcomes of the meeting. We also heard about discharge planning meetings where social workers would attend. We noticed that some of the detail on the TRAK system did not always reflect the details that were in the written care plan. For example, it was recorded that one person was on general observation levels, but this was inaccurate from reading the information in the paper file. Another MDT meeting record stated that an individual was a delayed discharge, when in fact they were not.

We are aware that the plan is for all records across NHS Grampian to become electronic at some point, and it was good to see that this ward had moved some documents and recordings to an electronic system. We were told this had improved communication as it had enabled other clinicians to gain access to treatment plans, however it is important that the information that is being submitted onto the system, or is autogenerated, is reviewed at the MDT meeting to ensure it is accurate.

We wanted to follow up on our recommendation about a protocol that the service is required to implement for individuals who were boarding from other areas prior to transferring to Brodie ward. We had identified on last year's visit that those individuals' care and treatment was not being reviewed regularly and had highlighted concerns about this. The SCN told us that there was regular review and input from the adult mental health consultants and we saw this in individual files. We were told that the protocol was being reviewed and we will continue to link in with senior managers about this.

We were concerned to hear that there were two individuals that continued to be recorded as 'boarders' and had been for a significant period, and prior to our visit last year. Those two individuals continued to remain in the ward and from reviewing files there were no plans to return those individuals back to the adult mental health wards. The consultant psychiatrist and the SCN told us that there were to be discussions happening to review their status, however there continued to be concerns about individuals remaining or being admitted to the ward who did not meet the criteria for the speciality of the ward.

Recommendation 2:
Managers must ensure that the boarding protocol clearly defines when an individual should no longer be classed as a boarder, what attempts should be made to move them to their regular ward and managers should also ensure that every boarder experiences continuity of care commensurate with being in their regular ward.

Use of mental health and incapacity legislation

Five individuals were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act), and of the files we reviewed, we found that the Mental Health Act paperwork was in order.

Part 16 (sections 235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were all in place.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity Act (Scotland) 2002 (the 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 AWI Act. Section 47 consent to treatment certificates were all in order, however we found two treatment plans where it was recorded that the person was receiving the treatment for their mental disorder. Our view is that where a person is detained under the Mental Health Act, that their treatment for mental disorder, is authorised under this legal framework and not the AWI Act.

We found that the s47 certificates were located in individuals' files and although they were easy to find, we suggested to the SCN that it would be good practice to keep all certificates authorising treatment together in the medication kardex folder.

For individuals who had an appointed legal proxy in place under the AWI Act, we saw a copy of the legal order in place, however, there was one legal order in place that had expired and there was a lack of clarity if the order had been renewed. We requested that the SCN contact the social worker to address this matter.

On reviewing individual files, we were pleased to see that most staff had recorded specific legal orders that individuals were subject to under the AWI Act legislation; this made clear the legal authority that was in place. We found that there were a few entries that recorded "AWI in place" however this was minimal. Following the Commission's publication of the *Authority to Discharge* report in 2021, the Scottish Government provided funding to develop an Adults with Incapacity framework for staff and this has been progressed jointly by the Commission and NHS Education for Scotland (NES). We will continue to keep the health and social care partnerships (HSCPs) and NHS Grampian appraised of this development as this will help to enhance staff knowledge base when working and supporting people subject to the AWI Act legislation.

Rights and restrictions

The ward continued to operate a locked door that appeared to be in line with the level of risk identified in the group. We were pleased to see that the ward had displayed the locked door policy beside the door to the ward, which was in pictorial format.

The ward continued to have good links with the local advocacy service and there was information on the ward about this service that individuals or relatives could access. We also saw advocacy input recorded in care records.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on individual who are detained in hospital. Where a person is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of the visit there was no individuals who had been made a specified person.

When we are reviewing files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and this 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 did not find copies of any advance statements and were told that the individuals on the ward would be unable to make one due to their progressive illness.

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 were told that activities were carried out by ward staff, and the activities co-ordinator. The activities co-ordinator has two and a half days per week in the ward, and we were able to see recordings of activities in the files we reviewed, along with separate activity care plans. The activity coordinator also kept a separate recording of activities. Where an individual had been in hospital for a significant period, we saw individualised planners were in place.

Individuals who we spoke with were able to tell us about some of the activities on and off the ward. The ward had access to a vehicle to take people out in the community, which individuals told us they enjoyed. Due to complexities of individuals' care, the staff told us that the ward benefitted from having access to the vehicle, as otherwise would be difficult to get people out.

The ward had a pool table and on the day of the visit, staff were engaging in activities with individuals, such as playing pool and board games.

The physical environment

The ward compromised of single en-suite rooms and dormitories. We were told that there were still occasions that individuals may have to share, however this was not the case on our visit. We saw an example where one individual had a dormitory to themselves, with access to their own bathroom, and the area had been personalised to make it more homely. Most

individuals had personalised their bedrooms, with pictures on the walls and televisions in their rooms.

The ward did not have a separate space for activities, as the room that was previously used was now being used as a sleeping area. One of the dormitories was being used for storage space, and it included people's wardrobes, a staff break out area and storage of arts, crafts, and ward equipment.

There was a dining area where individuals had their meals, with access to an enclosed garden. We saw that some improvement work had been done in the garden area since our last visit, to improve accessibility for individuals. However, on the day of the visit we saw that the slabs that had been laid were not even, potentially placing individuals at risk. We had a further discussion with the service manager, who was already aware of this issue, and was taking this forward.

Last year we were told that the SCN and consultant psychiatrist submitted a report to senior managers about bed capacity, and ensuring that the ward only admitted individuals who met the ward criteria. This report provided details to improve the physical environment in Brodie ward in order to support individuals, with an acquired brain injury or neurological disorder. We were told that there had been no response to this submission and therefore we will request an update from senior managers.

Summary of recommendations

Recommendation 1:
Managers must ensure that all risk assessments are regularly reviewed, updated, and discussed within the MDT meeting to ensure they accurately reflect each individual's assessed risk and that an agreed risk management plan is formulated.

Recommendation 2:
Managers must ensure that the boarding protocol clearly defines when an individual should no longer be classed as a boarder, what attempts should be made to move them to their regular ward and managers should also ensure that every boarder experiences continuity of care commensurate with being in their regular ward.

Service response to recommendations

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