Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 30 and 31 January 2024

Where we visited

We visited the four adult acute mental health psychiatric admission wards that were based in the Royal Cornhill Hospital; Huntly, Fraser, Dunnottar and Fyvie. Fyvie Ward was the most recently opened ward, opening in July 2023.

The four wards receive admissions based on a geographical area, and we were told that there had been recent changes to the catchment areas, which meant that some individuals had experienced changes to their usual admitting ward, as well as a change of consultant psychiatrist, social worker and/or mental health officer (MHO).

Huntly Ward had a catchment area predominantly that covered Aberdeen City, whilst Fraser Ward had a catchment area that covered Aberdeenshire. Dunnottar Ward covered Aberdeen City, Shetland and Ministry of Defence. Fyvie Ward had individuals admitted from Orkney, Aberdeenshire, and Aberdeen City. We were told on our last visit that individuals were often admitted to a ward that was out with their geographical area, and managers told us that the intention was always to transfer individuals to their aligned ward when a bed became available.

On the day of our visit, we found that there was significant number of individuals boarding out with their catchment ward and were told that the recent changes between inpatient catchment areas and the community mental health teams had had an impact on this. Managers told us that they hoped this would settle in time, however, we also were told that there were other individuals who were boarding out with general adult psychiatric (GAP) services and that the GAP wards had individuals boarding into their wards from other speciality areas, such as older adult services.

Managers told us that since Fyvie Ward opened, bed numbers had been bed capped to 18 beds in each ward, with an additional two surge beds, and that due to clinical demand the surge beds had to be used frequently. Each ward admitted individuals of mixed gender, and all wards offered a mixture of single rooms and dormitory accommodation. On the day of this visit, all four wards were at full capacity and the surge beds were in use.

Nursing staff, medical staff and managers expressed concern about the ongoing challenges of individuals boarding out of their ward, particularly around reviewing each individual's care and in keeping up-to-date with individuals' progress. All staff and managers told us that there continued to be an increase in crisis admissions from the community, with staff telling us that the continued level of clinical acuity had increased, therefore placing a demand on beds and staffing levels.

Managers told us about the significant staffing challenges, along with the bed pressures across the service and how this had continued since our last visit. Due to the ongoing demanding clinical need for admissions, we heard from managers how they have continued with a daily huddle to discuss bed pressures, admissions, and discharges, along with staffing numbers to ensure safe delivery of care. We were told this meeting also included a discussion as to which individuals may be suitable to be boarded to another ward. However, depending on clinical demand, those discussions often had to happen out with the meeting. We were told that medical staff and SCNs had the opportunity to put forward their views but that the

decision was sometimes made by the patient flow coordinator. We were told that there had been nursing and health care support workers posts recruited to since our last visit, which was positive, although we also heard from the SCNs that this meant there was often a level of inexperience across wards which placed an additional demand on the SCNs.

We last visited this service in March 2023, and made recommendations in relation to Mental Health Act (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) treatment certificates, Adults with Incapacity (Scotland) Act 2000 (the AWI Act) certificates, care planning, nursing documentation, risk assessments, patients' and carers' participation, multi-disciplinary (MDT) records, specified person documentation, and a locked door policy. We received a response from the service that included an action plan as to how the service planned to make those improvements, however this was not received until November 2023.

On the day of this visit we wanted to follow up on the previous recommendations and to hear about individuals experience across the wards, given that Fyvie ward had now opened. We had received calls to our duty advice line regarding individuals who had been boarded to other wards and had heard concerns about discharge planning, particularly where individuals, relatives, and professionals did not feel that the individual was ready to be discharged. We had been told about cases where this has resulted in a readmission, which was concerning.

Who we met with

Prior to the visit we held a Microsoft Teams meeting with the SCNs, clinical director for Aberdeen City, service manager and nurse manager.

On the day of the visit, we spoke with the SCNs, ward-based nursing staff, medical staff, consultant psychiatrist and clinical directors. We also met with advocacy service.

We met with 28 individuals from the four wards and reviewed the care and treatment of 22 individuals. We also spoke with eight relatives in Huntly and Fraser Wards.

Commission visitors

Tracey Ferguson, social work officer
Lesley Paterson, senior manager (practitioners)
Anne Buchanan, nursing officer
Graham Morgan, participation and engagement officer
Kathleen Liddell, social work officer
Gordon McNelis, nursing officer
Dr Arun Chopra, executive director (medical)

What people told us and what we found

Care, treatment, support and participation

Individuals across the four wards were at different stages of their recovery, with some individuals having been recently admitted to the wards, and others who had been in the wards for a longer period. There were a significant number of individuals who were detained under the Mental Health Act across all the wards, and due to increased levels of risk and acuity of mental ill health, some individuals had been placed on continuous intervention and required a higher level of staffing intervention. We met with several individuals across the wards where it was difficult to have detailed conversations with them due to the acuity of their illness, however we saw staff supporting individuals during times of distress and got a sense that individuals were aware of their rights and supported with this.

We heard from individuals about their admission process and how they had been admitted to another ward out with their geographical area. We heard that this was often difficult as they were unsure when they would be seen by their doctor or when they would be returned to their own ward. We spoke with a few individuals who told us about multiple moves and how their experience in one ward differed from another. Whilst some individuals told us of not feeling involved in their care, others told us that that they met with their doctor regularly, attended MDT meetings and felt really involved. Some individuals told us that they had been involved in developing their care plan and had a copy whereas others told us that they had not. Three individuals in Fraser ward told us that "it was good what they do with the care plan, they do it once a week and we get a say in what is in it and can add things if we want to".

Some individuals, across all of the wards, told us that there was not enough to do, which often led to boredom, however many others were able to tell us about their wide range of activities and groups that they attended to and how this supported them with recovery. Quite a few individuals told us about their involvement with the physiotherapist and occupational therapist (OT) and how they liked to go to the gym.

A few individuals that we spoke with in Fraser and Dunnottar Wards told us that the staff were "pretty good", "kind" and "caring" and that they could easily nominate several staff members for a DAISY award. The DAISY (diseases attacking the immune system) award is a global recognition programme that recognises and celebrates the skilled, compassionate care that nurses deliver daily.

Another individual in Fyvie Ward described the SCN as "a star", whilst a few others told us that the staff were "good, friendly and approachable." An individual in Huntly Ward described staff as "good and approachable" and that they "try their best."

We heard from some individuals across all the wards that it was sometimes difficult to speak with nursing staff because they recognised that they were so busy and told us that the staff were overworked.

Whilst some individuals told us that they felt safe on a particular ward, this experience differed across the wards. One individual told us that they felt safer in some of the wards than others and this often depended on the other individuals in the ward at that time. One individual described Dunnottar Ward as chaotic whereas another described the environment in Fyvie

Ward as not therapeutic however, they felt involved in their care and that communication was good.

We heard from a few individuals in Fyvie Ward that they had never seen their social worker, mental health officer or community nurse since admission, which was concerning given that the individuals had been assessed as fit for discharge.

Some individuals across the four wards told us that they had regular one-to-one sessions with staff whereas others told us they could approach staff when they needed to.

We asked individuals about the meals delivered to the wards and the views were variable. One individual in Fraser Ward described the food as good, whereas another told us that it was not so good and suggested that more fresh fruit should be available on the ward.

We spoke with some individuals who had been re-admitted back to the ward, shortly after being discharged and in one case, less than 24 hours. Some individuals told us that they did not feel ready to be discharged while others told us that they felt unsupported in the community. We will continue to link in with senior managers as we are aware that a significant adverse event review (SAER) was currently being undertaken for one case.

From all the relatives we spoke with, most of them told us that the communication was poor with the wards and that they all felt that they were the ones having to chase updates on their relatives. We did hear from one relative who told us that communication had improved since their relative had moved to Huntly Ward and that they felt more involved in their relative's care and treatment, which they told us was positive. One relative felt there was lack of facilities for children and families when they visit, and another told us that visiting times were confusing. Many relatives told us that they did not feel involved, and we heard from two relatives who shared their concerns about their lack of involvement with regards to discharge planning. We were made aware of a complaint that a relative had submitted to NHS Grampian and we will link in with senior managers as we are keen to know of the response.

Nursing care plans

The care plans and clinical records were in paper format, and we found these easy to navigate. We wanted to follow up on our last recommendation regarding care planning to see what progress had been made.

We had been aware from other local visits that there had been a working group devised to improve care planning documentation and processes across NHS Grampian and that this documentation has been piloted in various wards. We saw the new documentation and were able to see from reviewing files that the nursing staff were in the process of changing over all of the care plans to this new format.

We saw evidence of detailed person-centred care plans, with regular reviews taking place that evidenced individual participation, however, this was variable across the four wards. Most of the care plans we saw covered a wide range of needs however, we found a few that lacked in detail or failed to correspond to a person's physical illness.

In Huntly Ward, we saw a really good care plan that was in easy read format that supported the individual's understanding of their care and treatment and found another that was bespoke to the individual's complexities of their physical and mental wellbeing.

We also reviewed the continuous intervention care plans across the wards and found these to be detailed. We saw a care plan in Dunnottar Ward that was specifically for electroconvulsive therapy (ECT) treatment, but felt it required to be more detailed and fed this back to the SCN.

In terms of engagement and participation, we saw that some individuals had signed their care plans, and others, it was recorded that the individual did not wish to participate or sign their care plan. The process of engaging the individual in the care planning process had improved since our last visit, which we were pleased to see. We were made aware that there had also been a new evaluation form devised, however as many of the care plans had recently been transferred to the new document, some care plans were not at that stage, so no evaluation had taken place as yet. The SCNs told us that there was a new audit form that had been devised that was being trialled. We were told that the outcome of this will be taken back to the working group to see if further changes are required, before the documentation is implemented across the service.

We were pleased to see the work that had been done since our last visit around the care planning process and documentation however, the quality of the existing documentation was variable. We acknowledge the service is at the early stage of implementing the new documentation and we hope that having a robust audit programme in place will ensure that there is a consistent standard maintained across the care plans in the wards, which we look forward to reviewing on our next visit.

Recommendation 1
Managers should ensure that all nursing care plans across the service are individualised, person centred, and detail interventions which support individual's movement towards their care goals. These should evidence individual and carer involvement, be regularly reviewed and the quality of the care plans should be audited.

Where we found evidence of one-to-one discussions in the care records, we found them to be clearly recorded, detailed and capture the progress and improvements in the individual's mental state, on that specific day. However, the recording of one-to-one discussions was inconsistent across the four wards. We found some individuals had regular sessions, whereas for others, there were none recorded. There was no evidence if the individual had been offered a one-to-one discussion with staff and refused, or if these had not been offered. We did however feel that across the service, there had been improvement in recording of these sessions since our last visit, but note this was still at early stage of improvement and look forward to seeing further improvement on our next visit.

Last year we had some concerns about the use of language that was recorded in the notes, by staff. On this visit, we found language that was mainly recovery-based and meaningful, however we still found a few examples where phrases such as "brittle" "disgruntled", "kept a low profile", "visible on the ward" were recorded in care records, with no context or explanation provided, which was disappointing.

Most staff entries were detailed, and this was an area where there was evidence of improvement however, we continued to find some recordings that were minimal and contained very little detail about an individual's presentation, mental state or how they had spent their day.

We wanted to find out how the service was meeting last year's recommendation around risk assessment and risk management plans, as we found, at that time, that not all reviews were regular, robust, nor reflected the identified risk in accordance with the nursing updates and entries in the care records. In the care records, we found nursing assessments that had been completed at the point of admission, along with risk assessments and risk management plans. These documents continued to be recorded on the NHS Grampian patient booklet format and we were told that they were reviewed as part of the MDT meetings. We saw some risk assessments and management plans where there had been regular reviews and detailed updates, however, this was inconsistent across the wards, as we also found some that required to be updated or re-written due to the multiple updates on the record, which was similar to last year.

Recommendation 2
Managers must ensure that all risk assessments are regularly reviewed, updated, and discussed at the MDT meeting to ensure they accurately reflect the patient's assessed risk and that an agreed risk management plan is formulated. Compliance with this should be audited.

Multidisciplinary team (MDT)

We were told that each ward had a weekly MDT meeting, and we were advised that each individual's care and treatment was discussed at this meeting. The consultant psychiatrist and clinical leads for Aberdeen City and Aberdeenshire told us that the clinical input across the four wards had improved since our last visit. Although each ward had a consultant psychiatrist attached, we were also told about various other levels of input by other doctors such as CESR (certificate of eligibility for specialist registration) doctors. NHS Grampian are currently supporting nine CESR doctors across GAP services as a means of addressing vacant clinical posts and recruitment and retention. The CESR fellowship programme is a route for doctors who do not have general medical council (GMC) registration, nor have they completed an approved UK training programme, but are working towards gaining entry on to the specialist register. The three-year programme is specifically designed to provide international psychiatrists with all the necessary support, including GMC approved sponsorship, relocation support and bespoke mentoring and experience to achieve the CESR portfolio in specific psychiatric specialities. We heard from the clinical leads about support and mentoring for these doctors in Grampian.

We were told that the four wards had an MDT meeting recording template that was completed at the meeting by the nursing staff. The template appeared to be a robust document that recorded those in attendance, and had a variety of sections that included individual's progress, updates, treatment certificates, individual views/requests and legal status. However, on reviewing files, we frequently found again only first names recorded of the attendees and that the document had been completed to various standards across the four wards. It was unclear from reviewing the document if the individual attended the meeting or was part of the MDT

process. We found that some boxes had no entries, and some documents were not signed. For those individuals where there discharge planning was the focus of the meeting, we found there was a lack of social work and MHO involvement. We found that the level of detail in the consultant psychiatrists notes often differed and found that there was more detail and evidence of individual participation in the medical notes compared to the MDT meeting record.

We were told that each ward had a different approach to individual participation as part of the MDT. We were told that individuals on Fraser and Fyvie wards would attend the meeting, but individuals on Huntly Ward and Dunnottar Ward would tend to be seen out with the MDT meeting. We found that on the MDT meeting record that the individual views/requests sections were often left blank however, we did find views of each individual recorded in the medical notes. Individuals across Fyvie, Fraser, and Huntly told us that they felt involved in their care and treatment and that their views were taken into consideration. All individuals we spoke to in Dunnottar Ward told us that they did not feel involved or engaged as part of their care and treatment.

We are aware that NHS Grampian has a boarding protocol in place, and we heard from some consultant psychiatrists that it could be difficult to access intensive psychiatric care unit (IPCU) beds; we heard about a recent example of this on the day of our visit. We were informed that the protocol was in the process of being reviewed. We are aware from speaking to the doctors that it can be time consuming going to review individual's care across the hospital for people who are boarding out with GAP wards, however from reviewing MDT records we could see that this was happening, which was positive.

The wards continued to have input from OT, and we saw this on the day of the visit and from reviewing the care records. We found that some individuals had regular sessions with OT, and that were activity based, while others had assessments completed as part of discharge planning. We heard that OT continued to attend the weekly MDT meetings, where necessary.

We were told that the psychology input to the service was a much welcomed, and valued addition, and that there were groups running on a weekly basis across the wards. We saw posters displayed on the wards of when these groups were happening.

Recommendation 3
Managers should review the MDT meeting process and documentation across the service to ensure there is a consistent approach and recording mechanism in place. Individual and carer participation should be evidenced, and all sections of the MDT recording tool should be fully completed.

Use of mental health and incapacity legislation

On the day of our visit, 61 individuals across the four wards were detained under the Mental Health Act. This was an increase compared to last year's visit, where there were 44 individuals detained. All documentation relating to individual's Mental Health Act detention was in place, was up-to-date and easily accessible.

Part 16 (sections 235 to 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. We wanted to follow up on our recommendation from last

year's visit about Mental Health Act treatment certificates, given the concerns we highlighted in our visit report. NHS Grampian managers had submitted an action plan to the Commission as to how the previous recommendation was going to be met. The action was necessary to improve practice and governance with regards to individual treatment. Since our last visit there had a been an audit undertaken and we are aware of further planned audits. The pharmacist had provided a good practice guide for staff, which had been inserted into each individual's prescription kardex.

We reviewed the prescription kardex and consent to treatment certificates (T2) and consent to authorise treatment certificates (T3) of all individuals across the four wards who were subject to detention under the Mental Health Act. Although we did find some anomalies with regards to the legal authority in place to authorise the treatment in each of the four wards, there was some improvement from our last visit. We will continue to follow up these matters with the clinical directors.

We were pleased to see that there was a copy of the treatment certificates kept together with the drug prescription kardex for nursing staff to check treatment was authorised when administering it. In Dunnottar and Fyvie Ward we found some entries made by a junior doctor and the pharmacist in the care records. It would appear they had a differing view from the consultant psychiatrist, were querying the individual's ability to consent to treatment, and felt that a T3 was required as the individual was not able to consent to their treatment. There was no evidence to suggest these views had been taken into consideration, nor acted upon.

Recommendation 4
Managers must act timeously on concerns raised by the pharmacist on potential issues with authority to treat and ensure that there is an escalation process if potential issues are not discussed/addressed.

Recommendation 5
Managers must ensure that all psychotropic medication is legally authorised and regular audit undertaken to ensure the recent improvement in this area is maintained.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Some individuals told us that they had nominated a named person and we saw that this had been recorded in their file.

Each ward had a display board in the office that provided an overview of all individuals in the ward and where their legal status was recorded. Unfortunately, again, we saw recording of 'AWI in place'. Similar to our last visit, we found that this had been used; this often meant that a section 47 treatment certificate under the AWI Act was in place. We found across all four wards, where a person was subject to a welfare guardianship order, that the staff were not aware of this or that there was a copy of the order on file. We found some section 47 certificates which had expired, but nursing staff thought they were still in place. We found a distinct lack of understanding of the AWI Act legislative framework.

We noted that one section 47 certificate referred to interventions for 'agitation', however it would be our view that as the agitation was in the context of mental disorder, a T3 treatment certificate should be in place to provide the appropriate level of safeguard for this treatment.

The Scottish Government provided funding to develop an Adults with Incapacity framework for staff and this has continued to be progressed jointly by the Commission and NHS Education for Scotland (NES). We have continued to keep the Health and Social Care Partnerships (HSCP) and NHS Grampian appraised of this development, as this will only continue to enhance staff knowledge base when working and supporting people subject to Adults with Incapacity Act legislation.

Recommendation 6
Managers should carry out a training needs analysis and identify staff training gaps around Adults with Incapacity Act legislation in order to better enhance the workforce's knowledge base.

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 group. Each ward had a locked door policy displayed on the front door of the ward and had information displayed about individuals' rights on the board in the main corridor. Many individuals we met with during our visit had a good understanding of their rights and of the detention process, but some remained unsure.

We heard from individuals how the advocacy service had continued to support them and how they were regular visitors on the ward, often supporting individuals in meetings and mental health tribunals. We were told that advocacy held regular community meetings on the ward most weeks and how this enabled people to share their experiences collectively. We also spoke with the advocacy service, who told us that they regularly visited the wards and supported individuals.

We were aware that some of the wards had an information booklet which individuals reportedly found helpful in explaining certain aspects of the ward following admission. We saw that Fyvie had devised a booklet and Dunnottar provided a leaflet. The wards had lots of information displayed on the walls, however we also suggested that it may be helpful for all the wards to have a consistent approach to sharing and communicating ward information following admission.

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 an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. We wanted to follow up on our last recommendation about specified persons.

Where specified person restrictions were in place under the Mental Health Act, the documentation that was in place varied across the wards. We encountered issues related to the documentation, particularly in Dunnottar Ward, where we found no reasoned opinions in place for the six individuals who were subject to specified person legislation. This was concerning, as these were similar issues to those that we found on last year's visit. We also found that there was a lack of understanding with regards to staff's knowledge of this legislation across all four wards.

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

Recommendation 7
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.

Recommendation 8
Managers must undertake a training needs analysis in order to identify gaps in and enhance all staff's understanding of specified person legislation.

When we are reviewing patients' 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 a small number of advance statements in the care records however, we had a further discussion with managers about advance statements and how the use of advocacy services could support individuals with this and the importance of staff continuing to promote their completion at stages throughout admission.

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

Each ward had an activity planner displayed on the wall in the communal area of the ward. The wards had a suggestion box in the communal area for individuals to use.

We received feedback from the advocacy service on activities offered both on and off the wards, which individuals had shared with them during the ward community meetings. Individuals shared their positive accounts of activities on offer and how those activities supported their mental well-being however, some shared that they were often unsure about how to access activities.

In the communal area in each ward, there was a board that provided information about the daily meals menu, collective advocacy meetings, activity timetable and chaplain availability. The activity timetable included activities such as arts and crafts, baking, board games and pamper sessions. Physiotherapy offered a weekly exercise class and attended the wards regularly, supporting individuals to gym sessions. The psychology service was running groups, such as the coping skills group, which we heard was well attended.

We were told about the three new activity therapist posts that had been recruited to since our last visit and how they had supported activities on and off the ward. We found care plans that were linked to individual activities, that also included OT and physiotherapy groups. However, the recording of activities by the activity nurse was limited in some files and we got a sense that there was perhaps more happening that was not recorded.

Individuals told us about their input from the OTs, which provided group and one-to-one activities; we found detailed and meaningful recording of these sessions in the files we reviewed. Some individuals we spoke with across the wards were able to tell us about their activities such as cooking classes, lunch groups, art group and accessing the gym. Other individuals who were perhaps confined to the ward told us that the only activity they were offered was board games.

The physical environment

The four 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 may have a physical health need. Some individuals told us that they found it difficult to share a dormitory due to the lack of privacy and other individuals told us that they enjoyed the company of sharing with others. We were told that the door to the interview room in Dunnottar Ward had been broken since May last year and was just in the process of being fixed on the day of our visit. We were concerned to hear about the length of time it had taken for this to be fixed, particularly as this was the only room on the ward where individuals were able to meet in private with their doctor or nurse. The lack of private space was apparent during our visit, and we struggled to find an area to meet privately with the individuals who wished to speak with us. We were aware that this was being fixed on the day of our visit, as well as the fire exit door which was also scheduled to be fixed. We will follow this up with the SCN.

The ward environments were bright, clean and each ward had a dining area and separate TV area. Individuals told us that the wards could at times be chaotic, busy and noisy and this is what we found on the day of our visit. Although we saw good interactions between individuals and staff, we found that nursing staff seemed to mostly be based in the duty room, attending to administrative tasks, meaning that many individuals were often standing around the duty room, in the corridor, or knocking on the door in order to speak to the nurses.

Feedback from individuals across the four wards was variable with regards to the environment. Some individuals told us that they felt safe in the ward, whereas others told us they often felt scared and unsafe. A few individuals told us that the noise levels were difficult to deal with, particularly if they had sensory needs and the staff team also recognised this.

A few individuals had commented on how cold it was in Huntly Ward over the past few weeks and we heard how the communal cold tap in Fraser had been out of action for months but was now fixed. Individuals had shared feedback to advocacy that sometimes repairs could take such a long time, and provided the example of the TV being out of action one of the wards for a long period of time, which was difficult given there was only one television for everyone in the ward.

Recommendation 9

Managers must ensure a timely approach to requests for maintenance and repairs across each of the four wards, and there should be a clear escalation process should repairs remain outstanding.

Summary of recommendations

Recommendation 1:
Managers should ensure that all nursing care plans across the service are individualised, person-centred, and detail interventions which support individual's movement towards their care goals. These should evidence individual and carer involvement, be regularly reviewed and the quality of the care plans should be audited.

Recommendation 2:
Managers must ensure that all risk assessments are regularly reviewed, updated, and discussed at the MDT meeting to ensure they accurately reflect the patient's assessed risk and that an agreed risk management plan is formulated. Compliance with this should be audited.

Recommendation 3
Managers should review the MDT meeting process and documentation across the service to ensure there is a consistent approach and recording mechanism in place. Individual and carer participation should be evidenced, and all sections of the MDT recording tool should be fully completed.

Recommendation 4
Managers must act timeously on concerns raised by the pharmacist on potential issues with authority to treat and ensure that there is an escalation process if potential issues are not discussed/addressed.

Recommendation 5:
Managers must ensure that all psychotropic medication is legally authorised and regular audit undertaken to ensure the recent improvement in this area is maintained.

Recommendation 6:
Managers should carry out a training needs analysis and identify staff training gaps around Adults with Incapacity Act legislation in order to better enhance the workforce's knowledge base.

Recommendation 7:
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.

Recommendation 8:
Managers must undertake a training needs analysis in order to identify gaps in and enhance all staff's understanding of specified person legislation.

Recommendation 9:
Managers must ensure a timely approach to requests for maintenance and repairs across each of the four wards, and there should be a clear escalation process should repairs remain outstanding.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk