Mental Welfare Commission for Scotland

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

Date of visit: 14 May 2024

Where we visited

Muick Ward is a 20-bedded unit that provides admissions for older adults who have a diagnosis of a functional mental illness.

NHS Grampian has two older adult functional assessment wards, based in the Royal Cornhill Hospital, Muick and Davan Wards. In 2019, Muick Ward was decanted to Fyvie Ward and Davan to Drum Ward as part of the ligature reduction programme of works across the hospital site. Senior managers in NHS Grampian had continued to update the Commission about those ward moves and of the ongoing refurbishment works. The two newly refurbished older adult wards were due to open in September 2021, however there were significant delays due to issues with the water supply. The move back to Muick Ward took place in July 2023.

On the day of our visit, there were 21 people in the ward, with one surge bed in use. The senior charge nurse (SCN) told us that the ward had two surge beds and they would be used as and when required, depending on need across the older adult wards.

We last visited the ward, whilst it was decanted to Fyvie Ward in November 2020 on an announced visit and made recommendations on care planning and the mix of individuals in the ward.

On the day of this visit, we wanted to follow up on the previous recommendations and hear how the new environment was benefiting staff and individuals. We also wanted to find out how the service was implementing the actions from our *themed visit to older people's functional mental health wards in 2019*.

The SCN told us that the ward primarily admitted individuals from the Aberdeen City area.

Who we met with

We met with, and reviewed the care of 15 people, eight who we met with in person and seven who we reviewed the care notes of. We also spoke with three relatives.

We spoke with the SCN, service manager, nurse manager, the lead nurse, and ward-based staff.

In addition, we contacted the local advocacy service that is based in the hospital.

Commission visitors

Tracey Ferguson, social work officer

Alyson Paterson, social work officer

Denise McLellan, nursing officer

What people told us and what we found

We introduced ourselves to most of the individuals in the ward and chatted to them throughout the day. We were told that some individuals who had been admitted to the ward had a diagnosis of dementia, as well as a functional mental illness and some individuals had been diagnosed with dementia during their admission. The SCN told us that where a person had been admitted to the ward and received a dementia diagnosis, there continued to be ongoing discussions with the multidisciplinary team as to which ward would be best to meet their needs. The ward appeared to take a personalised approach to everyone's care, as opposed to moving individuals to the dementia ward solely based on their dementia diagnosis.

From our observations, the individuals 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 individuals about staff was positive. Individuals described staff as "caring" "supportive" "lovely" and "great". One individual told us that the staff team supported them in areas where they needed help, whilst another individual told us that the staff "listened to them" and that staff were "kind". Another individual described staff as "experienced" and liked how the staff checked on them regularly to make sure they were okay.

Some individuals told us about their regular one-to-one discussions with staff, and about their involvement in their care and treatment, but this view was not the same for all individuals that we spoke with. A few individuals told us that they had not seen their care plan and that they did not have regular meetings with their named nurse or the doctor.

While some told us that they liked to share a dormitory, and found the company supportive, one individual told us that they would have preferred to have their own bedroom. One individual described the bed as hard and said that they found it difficult to sleep due to being disturbed by other people during the night. This individual did tell us that staff were quick to respond those individuals during the night, particularly where they showed signs of distress.

Relatives we spoke with described staff as "excellent", "very approachable" and "experienced", whilst another told us that they felt the ward was welcoming and they enjoyed their visits with their relative. We heard from one relative that the communication was very good and that they felt involved in their relatives care and treatment. However, this was not the same experience for all relatives we spoke with. Some told us that communication could be better between relatives, the staff and the doctors, as this would help them feel more involved. One relative was not aware of the multidisciplinary meetings and was not aware of their relatives care plans. Where we heard feedback that was less positive, we followed this up on the day of the visit with the SCN.

The SCN told us that the ward was soon to be introducing community meetings that would provide individuals with the opportunity to discuss or raise any issues in relation to the ward. We also heard about plans to introduce the community meetings for relatives and carers, enhancing their involvement, participation and experience, which was positive to hear.

The ward had a detailed information leaflet that was given to relatives and individuals on admission. Admission to hospital can often be a difficult and worrying time for carers and

relatives, and whilst it was positive to hear that this information was provided on admission; we are aware that a lot of information at once, may be overwhelming for some. We suggested to the SCN that relatives' involvement and participation should be a theme that could be taken forward during the community meetings.

The leadership team consisted of the SCN and two charge nurses, of all who were full time. We were told that there were no current staffing vacancies. The SCN told us that there had been recent discussions with psychology to deliver stress and distress training to staff, given that the ward could often have individuals who presented with a functional and organic diagnosis.

Care, treatment, support and participation

We were aware of the new care planning documentation that has been rolled out across the wards in Royal Cornhill Hospital. This had come from a working group that had been devised to improve care planning documentation and processes across NHS Grampian. We saw the new documentation and were able to see from reviewing files that the nursing staff had implemented this change across all care files.

We saw evidence of detailed, holistic care plans that had been collaboratively written between the individual and staff, along with regular reviews taking place that evidenced individual participation, however, this was not consistently done. We also found that there was variation in the evaluations that were carried out. Where some were detailed and person-centred, others had minimal recording. In terms of engagement and participation, we saw that some individuals had signed their care pans, and others had recorded that the individual did not wish to participate or sign their care plan.

The process of engaging individuals in the care planning process had improved, which we were pleased to see. Although we could see some improvement in care planning documentation, the standard of recording was inconsistent, as was the lack of evidence of engagement and participation of relatives and families. The Commission has recently published a good practice guide as to how families can be involved in their relatives' care and treatment.

The SCN told us that regular care plan audits were being carried out using the new audit tool, which had highlighted the specific issues to take forward with staff.

As some individuals had told us about their regular one-to-ones with staff, when we reviewed their files, we found mostly good evidence of regular one-to-one sessions between individuals and staff. Most of these were detailed and meaningful, however we still found daily entries including phrases such as 'evident around the ward'. Although these were less, we had a discussion with the SCN about maintaining consistent standards across all care records. Where we found that one-to-one discussions were not happening, or less so, it was unclear if the person had been offered and refused, or if they had not been offered.

In the files we reviewed, we found detailed nursing assessments had been completed at the point of admission, both by the nursing staff and the medical staff. Risk assessments and risk management plans were also completed, however we highlighted a concern about one file where an individual's risk had significantly changed, and no review or update had been

completed on the document. We brought this to the SCN's attention and requested that this be urgently actioned, which they agreed to do.

Multidisciplinary team (MDT)

We were told that there were six consultant psychiatrists that covered the ward and that meant that there were six separate weekly MDT meetings taking place.

We would expect that all assessment wards would have timely access to psychology input, and we were pleased to see that the important role that psychology has in the treatment of functional mental illness in older people, both directly, with the individual, and by supporting nursing staff to deliver therapy was available in the ward.

The ward continued to have good support and access from a wide range of allied health professionals, such as dietetics, physiotherapy, and occupational therapy (OT). There was also regular access to a general practitioner (GP), who provided input to physical healthcare. A few individuals told us about specific interventions that had taken place since their admission. We found there was good attention to the link between physical and mental health care in the care records. The SCN told us that physiotherapy staff attended the ward most days to support individuals with mobility assessments and carried out daily exercise groups, which we saw on the day of our visit.

We were told that there was an MDT document that was completed at the weekly meeting. The template recorded attendees and had a variety of sections that included individuals' progress and updates, information on legal status, treatment certificates and the individual's views and requests.

We wanted to find out about individual participation as part of the MDT process of reviewing care and treatment. We were told that the MDT meetings continued to be a professionals meeting, however the consultant psychiatrist would meet with the individual after each meeting and at other stages during their admission. A few individuals told us that they met regularly with their consultant psychiatrist, which provided them an opportunity to feel involved in their care and treatment, but this was not the same for all. One relative told us that they felt very much involved and had attended meetings with the psychiatrist, however this was not a consistent view.

There was a section on the MDT record for individuals' views/requests, and whilst we saw recording of some requests/views, this was not consistent. It was unclear if individuals' views had been sought, and whether they did not, or did not have any specific requests, as this information was not consistently recorded in the continuation notes or on the MDT template. However, we did find that the individual's views on their care and treatment were often recorded in the medical notes, taken from their meetings with the doctor. Whilst we saw some meetings with relatives in attendance, it was difficult to know when and how often contact would be maintained with the relative, and if regular updates had been provided.

Recommendation 1:

Managers should develop a mechanism to ensure individuals and/or relatives are able to have their views considered as part of the MDT process and that feedback is given to individuals and/or relatives and clearly recorded in the care records.

We were told that there were five individuals that had been assessed as ready for discharge from hospital and that the delays were mainly around a lack of care home placements across the area. We were told that social workers and mental health officers continued to attend discharge planning meetings or MDT meetings when necessary.

Use of mental health and incapacity legislation

On the day of the visit, 12 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). All documentation relating to the Mental Health Act was in order and easily accessible in the individual's paper file.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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 mostly in place where required and corresponded to the medication that had been prescribed. However, there were two certificates that were not located in the file. We were told that these two individuals had a recent visit from a designated medical practitioner (DMP) and that copies of the T3 certificate had not yet been placed in the files. The SCN attended to this on the day of the visit.

On reviewing one individual's treatment certificate, we found that the DMP request had not been submitted on time and therefore there was a period that the individual had been receiving treatment outwith authority of the Mental Health Act. We spoke with managers on the day about this and requested that they provide written information to the individual about this, to ensure they were aware of their rights.

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. We did not find any named person documentation in the files that we reviewed, and it was difficult to know if this was an area that was discussed as part of the admission process.

For individuals who had a legal proxy appointed under the Adults with Incapacity Act (Scotland) Act 2000 (AWI Act), we saw copies of the legal order in the care records, apart from one. The SCN agreed to ensure that they requested a copy of the guardianship order that was in place.

Where a power of attorney (POA) had been appointed, it was difficult to know if the POA was activated or not as there was no specific recording in the file. We suggested to the SCN that this could be documented either on admission paperwork or in the care planning process.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the certificate. We found that the section 47 certificates were completed appropriately, including detailed treatment plans, except for one, which had an incomplete section. We brought this to the SCN's attention to action. We did find some treatment plans where the treatment for mental disorder was recorded for individuals who were subject to the Mental Health Act. Where an individual is subject to the Mental Health Act,

Part 16 authorises the treatment, therefore the specific treatment should not be recorded on the section 47 treatment plan.

There were some individuals who had a medication covert pathway in place however, on reviewing the documentation there were no review dates recorded on the pathway and it was unclear if the person was continuing to receive medication covertly. We brought this to the attention of the SCN on the day.

The Commission has produced good practice guidance on the use of covert medication.

Recommendation 2:
Managers must ensure that where covert medication is in place that review dates are clearly recorded and the ongoing need for covert medication is discussed at the weekly MDT meeting.

Rights and restrictions

The door to the ward was locked and a policy for this was displayed on the door. Although we felt this was proportionate for those who were detained, the rights of individuals who were admitted to the ward informally and did not require a door locked must equally be fully considered, so that they can have free access to the outside world. The Commission's view is that for those individuals, they should have written information and instruction, if necessary, on how to come and go from the ward. Managers told us that the locked door policy was being reviewed.

Most individuals we spoke with told us that they felt safe in the ward environment. There was one individual on continuous intervention due to the level of risk they presented. We reviewed their continuous intervention care plan, which appeared to be in order.

When we are reviewing individual 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 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. There was a rights pathway displayed on the large board in the ward that provided a variety of information and promoted patient rights.

We were aware that some individuals may not have been able to make an advance statement, but we did not find if this had been discussed at specific intervals during the admission process, as this was not recorded. We suggested to the SCN that this was an area that could be promoted at the future community meetings and could involve advocacy.

Recommendation 3:
Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing individuals with information and assistance with this. These discussions should be clearly documented within the clinical records, along with a copy of any advance statement.

There was a large white board on the wall of the staff room that displayed specific details about each individual. We found that others could view this confidential information, as the

staff room was surrounded by glass windows that individuals and relatives could view from the lounge area. We suggested to the SCN and managers to either move the board or place a screen over it. They agreed to address this as a matter of priority in order to preserve the privacy and confidential information of each individual.

This board also displayed each individual's time out of the ward, including that for those who are informal. Where we saw that some individuals who were informally admitted to the ward had their time out restricted, it was unclear if the individual had agreed to this or not. We had a discussion with managers about individuals' rights where they were not detained under the Mental Health Act. Whilst we are aware that some individuals may be at risk or require appropriate level of staffing due to their needs, the reasons for this should be clearly recorded in their care records, along with their recorded views. Those who are admitted to the ward informally should be aware of their rights around leaving the ward.

Where individuals had been detained under the Mental Health Act, we found they had been provided with information about their rights and had access to advocacy services. Some individuals told us about the support they had received from advocacy in relation to an appeal their detention and had knowledge about the role of the Mental Health Tribunal, however this was not the case for all.

We discussed a case with the SCN as we had noted from a review of the file that there had been particular adult protection concerns. The SCN told us that there were clear protocols and pathways in place across the hospital for reporting any adult protection concerns. In this particular case, although contact was made with social work, we felt that an adult protection referral should have been made to the health and social care partnership (HSCP).

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 individual records.

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.

Activity and occupation

We heard that the OT and physiotherapist provided activities to the ward and there was an activity planner displayed on the wall in the sitting area. Physiotherapy offered daily group exercises, which many people told us that they enjoyed. Activities were offered Monday to Friday, and we saw activities happening on the day of our visit. Mindfulness sessions were offered, and we heard from individuals of how they benefitted from these.

Some individuals told us about their outings with staff and that they enjoyed getting off the ward for a coffee or going to the shops, while another told us that it was good to get out for a walk and get the fresh air. Some individuals told us that they were kept busy on the ward and that there were plenty activities to do. However, while some told us that they were offered regular activities and chose not to participate, we got the impression from speaking to people that they would have liked to do more activities, but not in a group setting. We also heard from one relative that they would have liked to see more encouragement for their relative to participate in activities.

We got the sense from speaking to the staff that they recognised that therapeutic activities were important to support individuals with their stress/distress symptoms and we heard from them about the benefit and focus of activities.

We found recorded evidence in files of activities happening regularly for some individuals, but not for all and therefore it was difficult to know if individuals were asked to participate and declined or if they had not been offered. We asked the SCN if activities were offered on an individual basis and were told that the health care support workers and OT assistants provided this.

Recommendation 4:
Managers must ensure that all offers to participate in activities are recorded and all activities undertaken are documented and linked to individual care plans.

The physical environment

This newly refurbished ward was bright and spacious, and we were able to see the improved environment with the ligature reduction works completed. The ward further benefitted from the refurbishment in that the windows opened, allowing fresh air into the ward.

The ward was situated on the first floor of the building, with access via a lift to the lower floor, gaining access to the outdoor hospital grounds. The ward did not have specific access to a garden however, the SCN told us that there were discussions taking place about access to another ward's garden area.

The ward had a mixture of shared dormitories and single en-suite bedrooms. The SCN told us that they kept male and female dormitories separate and there tended to be four beds to a dormitory, with potential for five beds if the surge beds were required. Each dormitory had a level access shower with ample rails for support, as did the single bedrooms. The ward also had a separate bathroom with a large bath that had recently been fixed. There was a separate dining and sitting area that had ample seating and there were a few other quieter seating areas in the ward corridor.

The ward had a staff wellbeing room, and although small, this was dedicated space for staff to have their breaks on the ward, should they choose to. There was a separate room for the SCN, however that specific room did not have windows that opened, and we heard how it became very hot at times, similar to the staff office. Staff told us that the heat in the office could at times be unbearable.

Relatives told us that they tended to sit in the lounge with their relative during visiting times and enjoyed this however, we heard from one relative that they would have preferred some privacy but were unable to access the quiet room. We followed this up with the SCN and we were told that there were other options on the ward to offer a more private space, as opposed to sitting in the lounge with others.

There was good signage displayed around the ward and we heard about ongoing plans to enhance this further.

There was a variety of information displayed on the wall outside of the ward for relatives and carers, such as literature about other organisations.

Any other comments

During the previous visit, we observed that there was an inappropriate mix of individuals admitted for assessment of functional illness; assessment of dementia; and those individuals with adult acute mental health needs in the ward. One of the Commission's recommendations for services following the themed visit in 2019 to older people's functional wards was for authorities to ensure people with a diagnosis of dementia were not routinely admitted inappropriately to wards for older people with functional mental illness.

We are aware that there may be times when individuals with a dementia diagnosis were admitted to a ward for people with a functional illness. This may be appropriate when individuals with dementia required an assessment and treatment for a concurrent functional mental illness, or were early in the process of diagnosis, when it was not clear if the person has a functional illness or dementia. The SCN told us that this was the case, and that the ward predominantly admitted individuals with a functional mental illness.

We hear of the continued pressures on beds for older adults during our visits and the impact has worsened since the closure of some dementia wards. We had previously been told that there was a planned review of services for older people with mental health problems in Grampian however, on visiting other older adult wards, we were told that this was on hold due to other priorities.

The SCN and nurse manager told us about Grampian's progression on its 'pathway to excellence' journey and how three older adult wards had already been set up as a development group that have enabled shared decision-making and identifying improvements that were required across the older people's inpatient service. The accreditation programme recognises healthcare organisations for their nursing excellence, innovation, and quality patient care.

We will continue to request updates from managers about the planned review.

Summary of recommendations

Recommendation 1:
Managers should develop a mechanism to ensure individuals and/or relatives are able to have their views considered as part of the MDT process and that feedback is given to individuals and/or relatives and clearly recorded in the care records.

Recommendation 2:
Managers must ensure that where covert medication is in place that review dates are clearly recorded and the ongoing need for covert medication is discussed at the weekly MDT meeting.

Recommendation 3:
Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing individuals with information and assistance with this. These discussions should be clearly documented within the clinical records, along with a copy of any advance statement.

Recommendation 4:
Managers must ensure that all offers to participate in activities are recorded and all activities undertaken are documented and linked to individual care plans.

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 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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