Mental Welfare Commission for Scotland

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

Date of visit: 28 September 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and we are presently undertaking a variety of face to face and/or virtual visits. This local visit was able to be carried out face-to-face.

Skene Ward is a 16-bedded, mixed-sex dementia ward for patients who have a diagnosis of dementia and experience a level of stress and distress behaviours. Previously the dementia wards consisted of Davan, Strathbeg and Loirston. Due to refurbishment, patients in Davan Ward transferred to Loirston. Loirston Ward closed and those patients transferred to Strathbeg Ward. Strathbeg Ward closed and patients transferred to Skene Ward.

On the day of our visit there were 15 patients in the ward.

We were aware of ward closures in the dementia services for older adults in Aberdeen Health and Social Care Partnership (HSCP)/ NHS Grampian; where previously there had been three wards, there is now only Skene and we wanted to visit to review the impact of this. Managers told us that the current older people's service review is ongoing although has unfortunately has been delayed due to the pandemic.

Who we met with

We spoke with 10 relatives and carried out files reviews for six patients. We saw patients throughout the day in the ward and introduced ourselves to them.

We spoke with the senior charge nurse (SCN), ward staff and consultant psychiatrist. Contact was also made with advocacy service.

Commission visitors

Tracey Ferguson, Social Work Officer

Anne Buchanan, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Feedback from relatives was very positive. They told us that they felt involved in the care of their relative and were happy with the care and treatment by all staff. We heard from relatives that they found the staff to be caring and approachable, that communication is good and that staff always make themselves available to speak to them. For those patients who had been detained under the Mental Health Act (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), relatives told us about their contact with the consultant psychiatrist and Mental Health Officer (MHO). We were told that relatives had been advised of their rights, which had been explained to them in a way they understood and were fully kept up to date with the stages of the legal process, including the role and function of the Mental Health Tribunal Service (MHTS).

Some relatives told us that visits to the ward during the pandemic had been well planned by the staff and that they were able to visit in accordance with the 'essential visitors' criteria as outlined in the Scottish Government guidance. Whilst some relatives told us that visiting was important to them due the complexity of their family member's condition, we heard from other relatives that they were happy to be contacted by telephone.

On the day of our visit we saw positive interactions between the staff and patients. Where patients where showing signs of stress and distress behaviours, the staff responded promptly to the patients. On speaking with staff during the day, we were aware that there was a strong commitment towards meeting the patient's needs, a caring approach and enthusiasm by the staff team in the ward. The SCN told us that due to ward closures, there has been a lot of work done to bring the staff teams together, including training which appears to have worked well.

We were told that there have been significant staffing challenges across older people's services since the pandemic and this continues to be an issue. Managers have a daily huddle to discuss bed pressures and staffing issues, and we heard that there continues to be a recruitment drive to fill vacant posts; recently the service has managed to recruit newly qualified staff to vacant posts.

Care Plans

We saw care plans that were holistic, combined with daily reviews for each care plan that was then recorded in the patient notes. Care plans covered a wide range of holistic needs and included specific interventions for stress and distressed behaviours. Where the patient needs had changed, we were able to see that care plans had been updated following evaluation. We spoke with the SCN regarding one mental health recovery care plan where we felt it is required to be updated, due to the changes on the document. Regular one-to-one meetings with nursing staff were evident in the patient's notes, along with detailed occupational therapy (OT) assessments, including distress formulations.

We found thorough mental health assessments that contained good life history information. There were detailed risk assessments along with risk management plans in place for each

patient that were regularly reviewed throughout the patient's journey. We found one risk assessment that we felt should have been updated, and discussed this with the SCN on the day of the visit.

The SCN told us that the psychology input into the ward is good and that they support staff with specific training around dementia and work alongside staff in supporting patients and the whole team.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We found that attention was given to patients' physical health care needs along with assessment and treatment provided by dieticians, speech and language, physiotherapy, OT and psychology. The ward has a consultant psychiatrist, and input from a GP, who provides input regarding patients physical care. We were told that multidisciplinary team (MDT) meetings continue to be held weekly and that the ward has input from pharmacy. We reviewed MDT meeting minutes and were able to see a clear multi-agency approach to patients care, through the recording of these meetings. Whilst most MDT minutes were detailed, we had discussion with the SCN regarding one patient's file. We felt that further detail was required as the patient's discharge from hospital had been delayed and therefore considered it to be necessary to ensure recorded actions and outcomes were being met in a timely manner.

We saw a separate section in patients' files where there referrals to, and the involvement of other services such as physiotherapy and dietetics. There was also a separate section in the file where recorded communication was documented with other relevant professionals, such as a care manager, which we felt was positive and clearly showed who was involved in the patients care.

Use of mental health and incapacity legislation

On the day of our visit six patients were detained under the Mental Health Act. Mental Health Act paperwork in the records were well maintained and easy to access.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were all in order. Where patients had been assessed as requiring medication covertly, we saw detailed covert pathways in the files, along with appropriate reviews.

For patients who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), we saw copies of the legal order in place.

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. Section 47 consent to treatment certificates were all in order for each patient, along with accompanying detailed treatment plans.

The Scottish Government produced a revised policy on Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf).

This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. From the files that we reviewed we found that DNACPR forms had clearly recorded where proxy decision makers and families had been consulted, apart from one, where it was unclear. We brought this to the attention of the SCN on the day.

Rights and restrictions

We spoke with advocacy as part of the visit who told us that they continue to have involvement with the ward, even during the pandemic. We were able to see involvement of advocacy services from patient files and included in MDT or other case conference meetings where necessary.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

The ward has a therapeutic assistant who provides activities to the ward from Monday to Thursday. We were told that nursing assistants also provide activities during afternoon/evenings. The ward uses reminiscence interactive therapy activities (RITA) technology which is aimed at augmenting the care delivered to older people living with dementia. We were able to see patients and staff use this on the day of our visit. One-to-one and group activities were recorded in the patients' files and the ward has an activity planner displayed on the wall of the ward.

The physical environment

The layout of the ward consists of five single rooms and three shared dormitories. There is a lounge area and a separate dining area for the patients, both are bright and spacious. The environment was immaculate and we were able to see where efforts have been made to soften the public rooms.

The dormitory areas were less personalised for the patients. We had a discussion with the SCN about using personalised boxes to make the ward and patient rooms more homely. Staff told us about their plans to redecorate other parts of the lounge.

Some relatives told us that they were unhappy with the environment since the ward had moved, particularly with the lack of outdoor space. Skene Ward is situated upstairs and relatives and staff told us that they are no longer able to access the garden as easily as they once did. We heard how access to the garden from the ward really helped patients who were experiencing stress and distressed behaviours. Relatives told us that they missed going out to the garden with their family member and how enjoyable it was to be outdoors. We heard from a member of the clinical team that if the patients had access to a garden, the team thought that this would help manage some behaviours as opposed to using other interventions, such as medications, to manage some behaviours. We also heard how the garden area has been left to disrepair during the Covid-19 period. The lack of access to outdoor space concerned us, particularly access to the garden would have improved patient wellbeing. We consider that it is important for patients to have access to outdoor safe space.

Recommendation 1:

Managers should ensure that patients have access to outdoor space and that the garden area is maintained to provide a safe, pleasant, and easily accessible area for patients and visitors.

Any other comments

Managers told us that the older people's review is ongoing and that this will support managers to determine the required level of bed provision in the hospital. The transformation programme needs to consider the environmental impact on patients when a ward is moved and take this into consideration when designing the future provision. The Commission wishes to know the outcome of this review and will write to the managers for this.

Summary of recommendations

1. Managers should ensure that patients have access to outdoor space and that the garden area is maintained to provide a safe, pleasant, and easily accessible area for patients and visitors.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the receiving this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

SUZANNE MCGUINNESS
Executive Director (Social Work)

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 MWC 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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