Mental Welfare Commission for Scotland

Report on announced visit to:

Polmuir Road Community Rehabilitation Unit, 15 Polmuir Road, Aberdeen AB11 7RS

Date of visit: 18 August 2022

NB: this is an amended report which replaces a version which was published in error.

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Polmuir Road is a community-based rehabilitation unit which is part of NHS Grampian's rehabilitation pathway. Managers told us that a patient would tend to be transferred to this unit, where it has been identified that they would benefit from further rehabilitation in the community setting, aiding their recovery journey.

On the day of our visit there were nine patients in the unit, however two patients were out on pass.

On the day of this visit we wanted to speak with patients, relatives and staff. We also wanted to find out how the unit had implementing the recommendations from the Commission's themed rehabilitation report that was published in January 2020.

Who we met with

We met with, and reviewed the care notes of five patients. We also had telephone contact with one relative.

We spoke with the senior charge nurse (SCN), depute charge nurse (DCN) ward staff, the wellbeing and enablement practitioner and clinical nurse manager.

We also made contact and spoke with the local advocacy service.

Commission visitors

Tracey Ferguson, social work officer

Claire Lamza, executive director (nursing)

What people told us and what we found

Care, treatment, support and participation

We found that for patients in the unit, some had been in the rehabilitation service for several months, and for some, the duration of their stay has been over a period of years, due to their complex and enduring mental health needs. Patients had either been transferred from the in-patient rehabilitation ward at Royal Cornhill or referred via the community rehabilitation team.

Throughout the day of our visit, we spoke with most patients in the unit. Feedback from patients about staff and about their care in Polmuir Road was positive. We heard that the staff provided encouragement and help in developing the patient's rehab activities, that they were caring and had been able to build up good relationships with their named nurse; we heard that staff were quick to respond to patient needs and were supportive. Patients were able to tell us about their care and support plans, while we heard from others about their contact with the doctor and about their current treatment. We heard about the resident's meetings that take place every six weeks, where patients can raise a variety of issues that they see as important to them.

Some patients told us about their weekly planner and the activities that they enjoy doing, whilst others told us about what they wanted to achieve when moving on from the unit.

The relative that we spoke with told us that they were happy with the care that staff provided and told us that communication was good. The relative felt involved in the family member's care and that the unit has provided the 'stepping stone' before a tenancy in the community.

It was positive to hear that the unit has had no staffing issues. The SCN told us that this has enabled the team to provide a consistent approach to care and delivery for the patients in the unit. More recently the unit has recruited a wellbeing and enablement practitioner as a service improvement and development, with a real focus on enablement and outcomes, as part of the patient's rehabilitation journey.

Nursing care plans

Of the patient files we reviewed, we saw detailed holistic nursing assessments that were completed on admission, along with reviews that were updated regularly; these included risk assessment and risk management plans.

We spoke to the DCN about one of the patient's assessments that we felt needed updated. We also discussed the patient's risk assessment and risk management plan, as in reviewing the notes, we noted that the identified risks were significant and considered that a further detailed risk assessment was required to review whether the risks could be managed safely in the unit.

We found evidence of physical health care monitoring being provided throughout the patient's journey and were told that the GP visits the unit twice weekly to discuss patients' physical healthcare needs, which was recorded in the patients' files.

Care plans were reasonably detailed, including interventions and evaluation, however they varied in quality. The plans lacked definition and detail in relation in relation to rehabilitation

goals. We found it was difficult to see where the patient had progressed during their journey. The care plans had been developed from generic documents used throughout NHS Grampian mental health services and lacked a focus on rehabilitation. We had a further discussion about the documentation with the DCN and clinical nurse manager on the day. We were aware that the current documentation is limited for staff to use, and this was highlighted in a previous visit to the rehabilitation in patient ward, although the care planning documentation does consider the needs and strengths of the patient, which is helpful. We saw evidence of patient involvement in the care planning, where some had signed their care plans and others refused.

We were told that NHS Grampian will be moving to electronic recording in the near future which will provide an opportunity for the service, as a whole, to develop standardized rehabilitation-focused documentation.

We had a further discussion with the wellbeing and enablement practitioner, as we were aware that the practitioner has already began to develop systems and data that gathers evidence on individual outcomes, as part of monitoring patient's rehabilitation progress. We look forward to hearing about this new role and the benefits it brings to the service and patients.

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

Multidisciplinary team (MDT)

When patients are treated in a rehabilitation service we would expect that they have access to a full range of professionals that are involved as part of a multi-disciplinary team (MDT), and who provide the requisite skill mix to deliver care that is focussed on rehabilitation.

This unit has a consultant psychiatrist and a speciality trainee doctor (ST6). The consultant psychiatrist also covers the community rehabilitation team, and the in-patient ward, which ensures continuity for patients following discharge, or as part of their rehabilitation journey. We were told that the multi-disciplinary meetings (MDT) meetings continue to take place weekly and the MDT consists of the consultant psychiatrist, nursing staff, occupational therapy (OT) staff and clinical psychologist. However we heard that the unit has not had any input from OT or psychology for several months. Patients and staff told us that the input from both professionals has been a crucial component that has been missing from the MDT and has had an impact on the patient's rehabilitation. We were told that the psychology input has recently re-commenced and that the OT is returning on a part-time basis to the service in November; we were told that the recruitment process has started to fill the other part of the OT post.

We also heard that the pharmacy provides regular input to the MDT.

Although the unit has had no direct input from OT and psychology over the past months, we were able to see that the plans that had been put in place previously and how staff were continuing to implement these. We saw details of psychology team formulations and OT functional assessments that had been transferred into individual care plans.

We were pleased to see that there was involvement from the MDT in the planning and delivery of patients' care, however we would like to have seen a focus on trauma-informed work given patients' histories.

We also found that where patients required input from other specialisms, such as physiotherapy and speech and language therapists that this had been identified, discussed in the MDT and these services had been accessed as part of the patients' care and treatment.

In the MDT record we saw that there was an entry of who attended, with a detailed update for the meeting, along with a record of the outcomes and actions from the meeting. We were told that each patient has an initial review organised after a three month assessment period following admission to the unit, thereafter reviews are organised six monthly or sooner if there is a change in a patient circumstances.

We had a discussion with the managers about the standardised process for reviews of patients who have complex mental and physical health care needs and felt that it would be beneficial for the ward to consider approaches such as the Care Programme Approach (CPA) which provides a robust framework for managing patient care or using an Integrated care Pathway (ICP) approach.

Use of mental health and incapacity legislation

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

Part 16 (s235-248) 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.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we would expect to find copies of this in the patient's file. We found one patient's file where it has been recorded as to who their named person was however there was no documentation. We followed this up with the DCN on the day of the visit.

When we are reviewing patient files we looked for copies of advanced statements. The term 'advanced 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 found recordings in patients' notes, where a patient did or did not have an advanced statement in place. Where it was recorded that a patient did not have one in place, there appeared no follow-up discussion since the patient's admission in relation to this. One of the recommendations from the Commission's themed rehabilitation report was for NHS Boards to develop plans to promote understanding and the use of advance statements in rehabilitation services. We had a further discussion with the DCN about this and felt it would be beneficial for the service to build in these discussions into the patient's rehabilitation

journey, and continue to work alongside advocacy services, who could help promote patient's rights.

Rights and restrictions

S281 to 286 of the MHA provides a framework in which restrictions can be placed on patients who are detained in hospital. Where a patient is a specified person in relation to these sections of the MHA, and where restrictions are introduced, it is important that the principle of least restriction is applied. We were told that no patients had been made a specified person, however we found that staff had been removing items from a patient's belongings due to the risks and were carrying out searches to the flat and screening for alcohol. We discussed this further with the DCN and clinical nurse manager on the day. The Commission would expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed, along with reasoned opinions to be documented in the files.

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

The ward has good links with the local advocacy service which is based in the Royal Cornhill Hospital. From the files that we reviewed, we were able to see where patients had support from an advocate at meetings and tribunals. We were able to see that the unit also has good connections with mental health officers (MHOs).

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

Many of the patients in the unit have spent long periods of time in hospital, which can significantly affects the skills and abilities needed to live back in the community. We would expect that a specialist in-patient rehabilitation service would have individualised activities to promote recovery, and that these are recorded in activity planners/timetables, which would help patients gain or regain the skills and confidence they needed to progress their recovery.

We are aware that during the pandemic, the restrictions that needed to be put in place had an impact on various activities out with the unit, and that some of the patients have found this change to their routine difficult. Some patients told us about the impact of this and how this has been detrimental to their mental health and recovery. We were told that even where activities in the community had been cancelled, that the staff team continued to keep a focus on delivering activities in the unit and in the grounds of Polmuir Road.

We were told that the focus of the unit's OT is to provide functional assessments, and therapeutic-based activities on a one-to-one basis and in groups. However, with no direct OT input for past seven months, we were told that the staff team have been carrying out the groups with patients as part of their rehabilitation goals. With the addition of the wellbeing and enablement practitioner, we heard how this role has supported individuals to develop individual planners and recommence group activities.

Although we were told of activities being provided and offered, we found that there was a lack of recording in patient's notes about the specific activities that were participating in and how these benefitted the patient, as part of their rehabilitation. However, the wellbeing and enablement practitioner has developed a template that is being trialled at the patient's review which provides evidence of the patient's engagement in their activity programme.

The physical environment

The unit consists of five, two bedroom flats, along with a communal kitchen and lounge area. Each flat has a lounge, kitchen, bedroom and bathroom. In some flats, patients have en-suite facilities. There is a patio garden to the rear of the property that includes a shed, along with an area for planting shrubs and a BBQ.

Each flat, including the communal areas is in need of urgent redecoration and staff told us about other areas in each flat that had been identified for repairs. We heard from patients and staff about equipment that has not been working, for some time and has hindered their rehabilitation. We were told of five cookers across the flats that had been condemned and so far, none have been replaced. We heard how one cooker was identified and reported as far back as 2019. We were concerned to hear that patients in a hospital facility that's core function is rehabilitation did not have access to equipment, such as cookers, to support them with their rehabilitation programme, and were living in conditions that repairs were not being addressed in a timely way. We found that there was a lack of storage space in flats, which has led to avoidable clutter areas in bedrooms and living areas. Some individuals had been in the unit for several years, however their room lacked in personalisation. There was nowhere for patients/staff to dry clothes and no tumble dryer in all the flats.

We were told that NHS Grampian rent the building at Polmuir Road and therefore we urge managers to ensure contractual arrangements are in place to ensure any up-keep of the property is maintained, and works that are required are carried out as a matter of urgency. We had a discussion with managers about the environment and we will follow this up with managers to get an update.

Recommendation 1:
Managers must address all environmental issues to ensure patients have the appropriate facilities to aid with their rehabilitation activities and have a safe, environment to live in.

Finances

Staff told us that when patients are transferred to Polmuir Road, there are ongoing issues with their benefits, which takes up a lot of staff time and in some instances, patients have gone into debt. Staff have continued to inform the Department of Work and Pension (DWP) that the unit is a hospital facility however the DWP has continued to consider these patients as though they are in a community setting/own tenancy, which has resulted in patients being awarded payments that they are not entitled too. We had a discussion with managers at the end of the day and recognised that it was detrimental to patient's wellbeing if they were getting into debt while in hospital. We advised managers to write to the DWP in order to try and rectify this.

Summary of recommendations

Recommendation 1:

Managers must address all environmental issues to ensure patients have the appropriate facilities to aid with their rehabilitation activities and have a safe, environment to live in.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

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

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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