Mental Welfare Commission for Scotland

Report on announced visit to: Polmuir Road Community Rehabilitation Unit, 15 Polmuir Road, Aberdeen AB11 7RS

Date of visit: 8 July 2024

Where we visited

The service at Polmuir road is a 10-bedded, community-based rehabilitation unit which is part of NHS Grampian's rehabilitation pathway. Individuals are referred to the unit from the general adult psychiatry (GAP) wards or the rehabilitation ward, in the main Royal Cornhill Hospital, where it has been identified that an individual would benefit from further rehabilitation in the community setting, aiding their journey to recovery.

On the day of our visit, there were nine individuals in the unit. We were told out of the nine individuals, three were boarding from the acute wards at Royal Cornhill Hospital. One of those individuals was out on pass and we were told that discharge was imminent. We were told that another individual's discharge had been progressing well and that pre-discharge activities had been taking place for this individual, who had come through the rehabilitation pathway and was now ready to live in the community with support.

We wanted to speak with individuals, relatives and staff. We also wanted to find out how the unit was implementing the recommendation that was made in the previous report regarding improving the environment. We were satisfied with the response we received from the service.

Who we met with

We met with three individuals and reviewed the care of five individuals. We did not meet or speak with any relatives or carers.

We spoke with unit staff, service manager, the senior charge nurses (SCN), nurse manager, and consultant psychiatrist.

We also made contact with the local advocacy service based in Royal Cornhill Hospital.

Commission visitors

Tracey Ferguson, social work officer

Claire Lamza, executive director (nursing)

What people told us and what we found

Some individuals had been in the rehabilitation unit for several months, and for others, the duration of their stay has been over a period of years, due to their complex and enduring mental health needs. Individuals had either been transferred from the inpatient rehabilitation ward or the general adult psychiatric (GAP) wards at Royal Cornhill. Managers told us that due to bed pressures in the GAP wards, there had been times when individuals had been transferred to Polmuir Road, even though they did not meet the criteria for the service. Managers told us that discussions took place before any transfer, to ensure continuity of care.

Throughout the day of our visit, we introduced ourselves to most individuals in the unit. We had more in-depth discussions with some people, and the feedback we had was that staff were good at what they did. Individuals told us that the staff were supportive and caring. Individuals seemed to know who their named nurse was and spoke about the benefit from their regular one-to-one sessions. One individual told us that they liked the support that was available and felt involved in their care.

Individuals were able to tell us about the contact with the doctor, and of the regular reviews in place. However, one person, who had recently been transferred to the unit from the GAP ward spoke of the different process that they had experienced between the two services.

We asked managers about the process of admission to the unit and were told that transition plans were put in place when an individual was identified as ready for discharge and that the individual would benefit from rehabilitation. This process involved the key nurse meeting regularly with the individual, to explain the function and activities of the unit and of their involvement in their care and support, including access to the wider professionals.

Some of this information was provided in written format and we could see information displayed on the board in the entrance to the unit. However, we were aware that it could be overwhelming when a person was admitted to a new service and suggested that it would be helpful for the key nurse to have further discussions with an individual.

We were aware that there had been discussions with advocacy about specific leaflets for wards/service, which we felt would be helpful for individuals and families.

Resident's meetings, where individuals were provided the opportunity to raise a variety of issues they viewed as important to them continued to take place every six weeks.

Some individuals told us about their weekly planner and how they met the nurse on a weekly basis to plan their activities. One individual told us that they would have liked

to go out more often with staff, but sometimes staff were not available. All individuals we spoke with were happy with their accommodation, however, we heard from one individual who told us that sharing had taken a bit of time to get used to, as they had previously had a room to themselves. However, they recognised the benefits of having the other facilities in the unit.

It was positive to hear that the unit had continued to experience no issues with staffing and there was only one healthcare support worker vacancy, which they were actively recruiting for. The SCN told us that they had recently appointed a new charge nurse (CN) as the previous CN had moved to a post in the community.

Care, treatment, support and participation

Of the individual files we reviewed, we found detailed, holistic nursing assessments that were completed on admission, along with reviews that were updated regularly.

Where necessary, these included risk assessment and risk management plans, however we found that the risk assessment and risk management plans were not reviewed regularly or updated when risks had changed. The unit also had a one-page rapid risk assessment document and although we saw some evidence of review dates in some files, it was difficult to know what review processes were in place. We discussed one individual's case with staff on the day; we had noted that the risks had changed, although the risk assessment and risk management plan had not been updated or reviewed.

Recommendation 1:
Managers must ensure that there is a process put in place to review risk assessment and risk management plans.

We were aware of the new care planning documentation that was being 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. From reviewing files, we saw that the nursing staff had implemented this change across all care records.

We found evidence of holistic care plans that provided detail as to how individuals were going to meet their rehabilitation goals, however the level of detail across care plans was inconsistent. We found that care plans were being regularly reviewed, but there was variation in the evaluations that were carried out. Some were really detailed, whereas others had minimal recording, such as 'remains relevant'.

It was difficult to see where the individual had progressed during their rehabilitation journey and what changes were being made if goals were not being achieved. We found there was a good level of communication with families documented in the records, where relevant.

In terms of engagement and participation we saw that some individuals had signed their care plans, and for some, it was recorded that it had been discussed with them. We also viewed files where it was recorded that the individual did not wish to participate or sign their care plan. With variation in the quality-of-care plan reviews and evaluation, we suggested to the SCN that this should be captured in the new audit tool that has been devised to help improve care planning documentation.

Recommendation 2:
Managers must ensure that care plans reviews are detailed, meaningful and regular audits are carried out to address the quality of such reviews.

Care records
Individual care records were in paper format. Each file was organised with separated sections for information and the files were easy to navigate. We have continued to hear about the plans for NHS Grampian to move to a new electronic system in the near future. We were told that there were ongoing pilot sites testing the system, in the hospital, however there was no planned date for this to be rolled out to the service as yet.

Multidisciplinary team (MDT)
Where individuals are admitted to a rehabilitation service, we would expect that they have access to a full range of professionals that are involved as part of an MDT who would provide the requisite skill mix to deliver care that is focussed on rehabilitation.

The unit had a consultant psychiatrist and an ST6, a speciality trainee doctor. The consultant psychiatrist also covered the community rehabilitation team, as well as the inpatient ward, which ensured continuity for individuals following discharge or as part of their rehabilitation journey in moving from an inpatient setting to community. We heard from individuals that they found this continuity helpful.

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

We noted that the MDT meetings continued to take place weekly, and that the MDT consisted of the consultant psychiatrist, nursing staff, occupational therapy (OT) and clinical psychology. However, we heard that the unit has had little input from psychology since our last visit, due to absence, and prior to this, the unit had not had consistent input from this speciality. We discussed this further with the staff team and consultant psychiatrist, who told us that individuals' recovery and outcomes were impacted due to this crucial professional discipline being missing from the MDT, and thereby having an impact on people's rehabilitation.

We were told that the lack of psychology provision had continued to be escalated to senior managers and that recently the unit had been provided with three hours of

psychology input a week from a trainee who had begun to work with some individuals. Although this was positive to hear, we raised concerns about the lack of current psychology provision for the unit that has not improved since our last visit in 2022.

Recommendation 3:
Managers must ensure that the unit has sufficient psychology input at all times to aid individuals' recovery and rehabilitation.

We also heard that pharmacy provided regular input to the MDT meetings, where issues of treatment were discussed. The unit had the equivalent hours of one full-time OT attached to the service. We were told that there were two part-time OTs in place, although prior to our visit, due to absence of one of the OTs, there had been an impact on what this service had been able to deliver. We were advised that one of the OTs was also due to leave, but that the other OT would pick up some of the additional hours.

The MDT meeting record provided details of who attended the meeting. There was a progress update from nursing staff and recorded actions and outcomes from this meeting. We asked about individual participation as part of the MDT meetings and were told that individuals did not attend this meeting, as they met separately with their doctor at the clinic.

We noted there was a section on the MDT record for recording individuals' goals and views, along with any requests. However, we saw that these were often left blank and were unsure if the individual had been asked or not. For the individuals who were boarding from other areas we asked about the process of review in place for them. We were told that the nursing staff would complete the MDT record and email this to their doctor. Staff would either support the individual to meet with their doctor or the individual, if able to would attend the ward meeting at the main hospital by themselves.

Staff explained that the usual method of communication was by email and if they had any concerns, they would contact the ward or doctor. We are aware that NHS Grampian is reviewing their boarding protocol and will link in with managers following this review.

We wanted to know about the review processes in place as part of individuals rehabilitation journey and were told that all individuals had an initial review organised after a three-month assessment period of being in the unit. This meeting was attended by all the MDT, including the allocated social worker, the individual and their relative/carer where possible. We were told that individuals were involved in the preparation of the paperwork and of the organising of the invitations before the review took place, to encourage a person-centred approach.

We saw records of these review meetings and some individuals had their advocate supporting them during this process. Following this meeting, a further six-month review would be scheduled, unless there was a significant change in the individual's circumstances. We were also told that the unit arranged discharge review meetings in order to support the transfer of care to the community, once the individual was ready to progress to that stage.

We discussed one case with the staff team, as we were aware that there was consideration of a community placement, but there had not been a copy of the social work assessment provided, which would inform these considerations. We advised staff to request a copy of the social work assessment prior to the next review meeting.

Although the review records were detailed, we felt that there were parts of an individual's care and support that were not discussed in this progress meeting and it was difficult to determine the goals that had been achieved, or that needed to be achieved, or met. We found that the link between the current documentation did not provide a holistic update as part of this review meeting.

From our last visit we wanted to find out if the unit had considered implementing approaches such as the Care Programme Approach (CPA), or an Integrated Care Pathway (ICP) approach, which would have provided a more robust framework for comprehensively managing the range of needs of individuals' care, however we were told that this had not been considered. We would again recommend that Polmuir Road link with other rehabilitation services that use these frameworks to consider how deliver the use of approaches such as CPA or ICPs can provide more joined-up, needs-led, goal-oriented care.

Recommendation 4:
Managers should implement a standardised multidisciplinary framework for reviewing individuals' care and treatment in the rehabilitation setting, such as CPA/ICP.

From speaking with staff, we found that the unit had a strong focus on person-centred and multi-agency approach to individuals' care and treatment, however this was, at times, lacking in the documentation.

Use of mental health and incapacity legislation

On the day of our visit, three individuals were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act).

Of those people that were subject to compulsory treatment, we reviewed the legal documentation available in the files and found that all Mental Health Act paperwork was in order.

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 in place where required and corresponded to the medication being prescribed.

All certificates were kept together with the medication kardex and were accessible.

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. Where an individual had nominated a named person, we found that this was clearly recorded in the individual's file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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 form. We saw in one file where it referred to an 'AWI' being in place and there was lack of clarity from staff as to what this referred to.

For those people who were subject to AWI Act legislation, we found copies of the legal order in the file. We are aware that there was a training needs analysis taking place following a recommendation that the Commission made in another Grampian service and therefore feel it would be prudent to also address this across this service to support staff to gain knowledge around AWI Act legislation.

We would also suggest that any section 47 certificates are kept together with treatment certificates.

Rights and restrictions

The door to the unit was kept locked and we were told that all individuals had a key to the unit.

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 found where a person was able to make an advance statement that there was a copy of this is the file. We noted that if there had been a discussion about an advance statement and an individual rights, it was not recorded as part of the formal review meetings, as suggested on our previous visit. Again, we would emphasise that it would be beneficial for the service to build these discussions into the

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

Sections 281 to 286 of the Mental Health Act provides 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. On this visit, no individuals were subject to specified person legislation.

The ward had good links with the local advocacy service who are based in the Royal Cornhill Hospital. From the files that we reviewed, we were able to see where individuals had support from an advocate at meetings and tribunals.

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 would expect that a specialist inpatient rehabilitation service would have individualised activities to promote recovery, and that each individual should have activity planners/timetables that enable them to gain or regain the skills and confidence needed to progress their recovery.

We were told that the unit had dedicated OT input to provide therapeutic-based activities on a one-to-one basis and in groups. We saw recorded evidence of OT input, including assessments that included goal setting with individuals as part of their rehabilitation journey. These entries were detailed, person-centred and included the views of the person.

Individuals were able to tell us about their activities and their work with OT and we found evidence of some of this in the files we reviewed. However, a few individuals made comment to us that they would have liked to do more and get out and about more. The staff recorded time spent on each activity for every individual each week on their board in the staff office. These figures were collated each week and brought to the MDT meeting. As this was recorded in hours, it was difficult to know if this was part of the assessed needs and planned goals or if these were activities the individual chose to do.

The activity hours that the individual declined to participate in were also recorded. On reviewing records, the amount of hours varied for individuals and where we found that the record of an individual declining an activity, we did not find reasons why, nor was there a link to the care plan, if it was not working.

It was difficult to know exactly what input OT had to the service, as this was not always clearly recorded in the documentation. We wanted to find out more about the

addition of the well-being and enablement practitioner, following our last visit. We were told that this role had made a positive contribution to individuals and that the practitioner continued to collate data to evidence individual outcomes that were presented to the review meetings. We heard how the practitioner had continued to support individuals to develop individual planners and develop group activities, including better links with community as part of transitioning for discharge.

The physical environment

The unit spanned over three floors and consisted of five, two-bedroom flats, along with communal kitchen and lounge area. Each flat had a shared lounge, a shared kitchen, two bedrooms and a bathroom. In some flats, individuals had en-suite facilities and others were required to share a bathroom. We were told that depending on individual need, staff sometimes had to assist individuals to keep their flat in order, with issues such as cleaning.

All individuals we spoke with had no concerns with their flats and liked their environment, as this was the next stage in their recovery journey.

There was a patio garden to the rear of the property that included a shed, along with an area for planting shrubs and a BBQ.

Following our last visit, we followed up with managers and were pleased to hear that action had been taken to replace the cookers. Each flat had all the necessary equipment to support rehabilitation and promote the learning of new skills. We were told and were able to see all the work that had taken place in the flats since our last visit. We saw that the sky window had been replaced in the building and there continued to be a regular walk around with managers taking note of any issues and these were then raised with estates. We saw that settees in the communal area were ripped and required replacing. We were told that this had been raised with senior managers some time ago, so we will request an update from managers with regards to this.

Summary of recommendations

Recommendation 1:
Managers must ensure that there is a process put in place to review risk assessment and risk management plans.

Recommendation 2:
Managers must ensure that care plans reviews are detailed, meaningful and regular audits are carried out to address the quality of such reviews.

Recommendation 3:
Managers must ensure that the unit has sufficient psychology input at all times to aid individuals' recovery and rehabilitation.

Recommendation 4:
Managers should implement a standardised multi-disciplinary framework for reviewing individuals' care and treatment in the rehabilitation setting such as, CPA/ICP.

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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