Mental Welfare Commission for Scotland

Report on announced visit to: Loirston and Strathbeg Wards, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 4 June 2024

Where we visited

NHS Grampian's inpatient learning disability service consists of two wards, Strathbeg and Loirston, both of which are located on the main site of Royal Cornhill Hospital.

Strathbeg Ward is an eight-bedded ward that provides admission for adult males with a learning disability diagnosis, who present with behaviour that may be harmful to themselves or others, and who require close supervision in a secure environment.

Some individuals who had been admitted to this ward had come via the forensic pathway and had been assessed as requiring a lower level of security. The ward covers the northeast area of Scotland and admits individuals from Grampian, Highland, Shetland, and Orkney. On the day of our visit there were six people on the ward.

Loirston Ward is an admission service that provides assessment and treatment for adults with a diagnosis of a learning disability and/or autism, who have a psychiatric illness and/or present with behaviour that is complex to manage. Loirston Ward has eight admission beds, and on the day of our visit, there were five people on the ward.

Managers told us that between the two wards, the current capacity continues to be capped at a maximum of 13 people. Loirston Ward had one individual who was boarding from another ward. We asked managers about the boarding situation to these wards as we had found on our previous visits, and on other visits across the hospital, that individuals were at times having to board outwith their geographical ward and areas of specialism.

We were told that due to the current numbers on each ward and the complexity of individuals across both wards, there had not been capacity to regularly accept individuals from other wards areas.

We last visited this service in May 2023 on an announced visit and made recommendations about a seclusion policy and a functionality assessment of both ward environments. We received a response from the service that included a detailed action plan as to how the service had planned to meet the actions. On the day of this visit, we wanted to follow up on these recommendations.

We also wanted to find out more about the delayed discharges of individuals who had been waiting to leave hospital for a significant period of time.

The learning disability nurse consultant told us that since our last visit the service had undergone a peer audit that assessed them against the Queen's Nursing Institute (QNI) and Queen's Nursing Institute Scotland (QNIS) voluntary standards, that were published in 2021.These standards were developed for community learning disability nurse education and practice, for nurses who had undertaken a

Nursing and Midwifery Council (NMC) approved post-registration specialist practitioner qualification. We were told that the wards were part of the pilot programme, that improvement areas had been identified in the report, and that the service was now looking to take these actions forward. This was positive to hear, as we were aware that the projected priorities of the NHS long term plan is to address health inequalities, unmet needs and to ensure people with a learning disability and/or autism experience improved outcomes. Managers agreed to share the report with us.

Who we met with

We met with four individuals in Strathbeg Ward and reviewed each of their care records. We spoke with four relatives.

We met with two individuals and reviewed the care of three in Loirston Ward and spoke with one relative.

We spoke with ward-based staff, the service manager, the senior charge nurses (SCNs), the learning disability nurse consultant, the nurse manager and the consultant psychiatrist.

We also made contact with the local advocacy service.

Commission visitors

Tracey Ferguson, social work officer

Anne Buchanan, nursing officer

Susan Tait, nursing officer

What people told us and what we found

Both SCNs told us that due to the complexity of individuals across both wards, there were rare occasions where an individual's specific needs could not be met on that specific ward and as a service, they continued to have ongoing discussions about the best approach, including where the individuals' needs could be best met. This was evident on the visit, as we were aware that an individual who had been on Loirston Ward was transferred to Strathbeg Ward, to an area that enabled them to have their care and treatment delivered in a person-centred way, having their own space and privacy, while on continuous interventions.

Both SCNs told us about staffing vacancies across the wards and the challenges in the recruitment of learning disability nurses. Both SCNs were learning disability nurses and both wards also had mental health nurses. We were told that both wards used bank staff, depending on clinical need, and where bank staff were used, the staff were from a regular pool; some staff had previously worked in the wards. The nurse consultant told us that due to the challenges of recruiting learning disability nurses, a group had been formed in the north of Scotland, looking specifically at recruitment campaigns and linking in with the universities with regards to different training routes to support learning disability nurse training.

We were also told that the service had recently advertised for a clinical nurse specialist role, and that the focus of this role included workforce succession planning, particularly around the recruitment and retention of learning disability nursing and other aspects, such as training and interventions specifically for people with a learning disability and/or autism diagnosis.

From the individuals whom we spoke with in Strathbeg Ward, we gained a sense that activities were important to them. People told us they liked routine and structure and were all able to tell us about their structured timetables and of the activities that they participated in, off ward. One individual told us that they would like to have more time outdoors. Individuals told us about the input they had from professionals, such as occupational therapy (OT) and psychology, and about their regular meetings with the consultant psychiatrist and their involvement in care programme approach (CPA) meetings. CPA is a framework used to plan and co-ordinate mental health and learning disability care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre of care.

One individual told us that they liked their daily 'talk time', as this provided them with regular meetings with staff, and told us that they felt listened to and that meetings enabled them to share their views.

Most individuals were able to tell us about their rights, including their involvement from advocacy and legal services, as well as their involvement in their care planning process.

All individuals told us that the staff were “good” and that staff took their time to get to know them as individuals. One individual told us of their frustration with the lack of progress with regards to their discharge to the community and how they felt it was unfair that they continued to be in hospital.

Due to the complexity of individuals in Loirston Ward, we were not able to have detailed conversations however, we observed individuals and introduced ourselves to them. Where individuals were on continuous interventions, we saw staff engaging with them and responding to their needs in a supportive and calm manner.

Where an individual expressed that they did not want to be in the ward, we were satisfied that their rights were safeguarded and that they had the support of advocacy services.

Feedback from relatives/carers from both wards was consistently positive. Relatives told us that they felt engaged and involved, where they could be, and attended regular meetings to discuss their relatives’ care and there was forward planning. Relatives told us that the staff team were “really good” and had a “wealth of experience”.

One relative told us that they felt listened to and received regular updates when they phoned the ward. Another relative complimented the staff team, telling us that all members got to know their son quickly and it did not matter who they spoke with, they always received a detailed update.

Another relative told us that they were relieved that their relative was being looked after and cared for, and that the staff team knew best how to support them. One relative described the “positive difference” that they saw in their relative since admission, and they put that down to the staff’s approach and skills, including the input and various assessments by the range of multidisciplinary of professionals.

Care, treatment, support and participation

From reviewing the care files, the level of detail in the documentation was evident and provided a sense of the staff’s investment in getting to know the individual and what was required to meet individual outcomes, from the admission stage and throughout their stay in hospital.

We found detailed nursing assessments across both wards and where a person had been in the ward for a longer period, these had been updated. Detailed risk assessments and risk management plans were in place, and we saw that those documents had been regularly reviewed. We were told that as part of discharge

planning process, risk assessments and risk management plans were reviewed and updated, which we saw in the files. We reviewed one person's risk assessment and risk management plan which was complex due to issues of public protection. However, the way in which the staff devised this and delivered this still ensured that the individual's well-being in accessing community facilities was a priority, whilst also managing risk.

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. We were told that the wards had not yet implemented this documentation, as some adaptations were required to meet the needs of the service.

We saw evidence of detailed, holistic care plans, with regular reviews taking place that included individual participation and documented a multidisciplinary approach to each individual's care and treatment. We saw regular reviews of those care plans with recorded evaluations. We highlighted one care plan evaluation to the SCN on Strathbeg Ward. Although the care plan had been evaluated, there was some of the information that was incorrect and had not been updated as part of the process. We found care plans that had been devised as 'easy read' or were in a pictorial format to support individual involvement and understanding. We saw recorded evidence where individuals were involved in their care plans, as far as possible, as well as family involvement. We found that there was a good level of communication with families in the files, where relevant.

Where individuals were on continuous interventions, there was regular and detailed reviews in the documentation, along with the well-defined care plans, that recorded specific interventions and de-escalation techniques that best supported the individual.

The level of detail in the staff's daily recording entries were generally of a good standard, however, we found a few where the recording was minimal and we felt staff could have provided more detail, as opposed to recording the person was 'evident in the ward'. We also found that staff had recorded detailed information about application of behaviour strategies, however we suggested that more finer detail about the triggers, what strategies worked what happened afterwards would have been of benefit in one of the care files that we reviewed.

We saw evidence of annual health checks, physical health care and monitoring being carried out. The wards continued to use the Health Equalities framework (HEF) which is an outcomes framework that measures health outcomes for people with learning disabilities. We found detailed recordings in relation to physical healthcare monitoring and intervention. The importance of physical healthcare was evident through the assessments, care planning and daily observations.

The SCN in Loirston Ward told us about a quality improvement project that was carried out on the ward and involved an individual with complex and sensory needs, who on admission was very unsettled, anxious and showed daily behaviours that challenged, often leading to restraint and 'as required' medication. Through the use of specific proactive strategies implemented by nursing staff, the OT and psychology, there was significant improvement in the individual's quality of life and the SCN provided us with visual data that evidenced the decrease in restraint and 'as required' medication use since increasing the proactive measures for the individual, which was positive to see.

Care records

Individual care records were in paper format, with each file organised into separate sections for information; the files were easy to navigate. Information was also accessible for individuals where care plans had been provided in pictorial format and using accessible information, depending on individual need.

We 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, however, there was no planned date for this to be rolled out to the learning disability service.

Multidisciplinary team (MDT)

The wards continued to have comprehensive input from a range of multidisciplinary professionals into people's care and treatment, working effectively in addressing the holistic needs of individuals whilst managing identified risks.

MDT meetings took place every week and we saw recorded minutes of these, with noted actions and outcomes. Pharmacy also attended the meetings and carried out regular audits. All people in Strathbeg Ward continued to be managed using the care programme approach (CPA). This provides a robust framework for managing care, particularly in relation to the management of risk.

Individuals did not always attend the weekly MDT meeting but had an opportunity to contribute; the consultant psychiatrist told us that he met with individuals before or after meetings, as did nursing staff. Most meetings continued to happen via video link, and we were told that individuals/welfare guardians/social workers and advocates, also had the option to attend, where appropriate. The service has found that in using virtual meetings, there has been greater attendance, particularly where the individuals' home areas were outwith NHS Grampian. Individuals continued to attend their CPA meeting, where they wanted to, and we found the CPA meeting minutes to be detailed, with recorded actions and outcomes. Some individuals had the support of their advocate at those meetings, which enabled individuals to contribute their views and experiences in a supported and positive manner. Where an

individual chose not to attend their meetings, we felt that their views were not always recorded in the documentation and discussed this with SCNs.

From reviewing the files, we found that the wards were focussed on a person-centred and a multi-agency approach to individuals' care and treatment. We found OT and psychology assessments/formulations, as well as regular input from the consultant psychiatrist. There was regular input from speech and language therapy that ensured the continued use of effective communication strategies to engage people and promote participation. This included easy read version of documents, such as pictorial activity planners.

Following on from our last visit, we have continued to follow up on individuals progress with regards to discharge planning. It was positive to hear that some individuals had been discharged to community placements and both SCNs told us that the inpatient team worked closely with care providers, where the care staff would come into the ward and shadow the nursing staff; this joint working made the transition more successful.

We were told that there were three delayed discharges in Strathbeg Ward and four people delayed in Loirston Ward at the time of our visit. Whilst there had been progress with some discharges and active planning, we were concerned to hear that there was no clear pathway for others, which could lead to long delays in hospital.

We heard that the lack of progress had been mainly around no suitable accommodation in the community, along with significant care packages that were required. We were aware that some individuals had recently been assessed as ready for discharge and that there were regular meetings where plans were discussed.

We will continue to follow up on two individuals, where the delays had been significant.

Use of mental health and incapacity legislation

On the day of our visit, six individuals in Strathbeg Ward and four individuals in Loirston Ward were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure 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. The consultant psychiatrist had brought two cases to our attention where a designated medical practitioner (DMP) request to undertake an assessment where T3 certificates were required had been made, but this had not yet been completed. We followed this up and dates were given for these to be undertaken.

The ward had a Mental Health Act checklist in the files that reflected each individual's legal position and was regularly updated.

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 along with a copy of the documentation.

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 where an individual had a section 47 certificate in place, there was also a completed detailed treatment plan. For those people that were under the AWI Act, we found copies of the legal order in the file.

Rights and restrictions

Across both wards, the majority of individuals were subject to detention under the Mental Health Act or Criminal Procedure Act. Both wards were locked, and there was a locked door policy in place that was balanced with the level of risk being managed, particularly in Strathbeg Ward. We were aware from other visits that the NHS Grampian locked door policy was under review.

Each patient in Strathbeg Ward had their own detailed escort plan, as a number of individuals who required their time away from the ward to be supervised. Individual escort plans were reviewed regularly by the MDT and amended where necessary.

There was one individual in Loirston Ward that was informal and they were out on the day of our visit. From reviewing records, the staff and MDT continued to obtain the individual's views about their admission and being on the ward. We were satisfied that this individual was aware of their rights.

Where nursing staff were providing support to individuals under continuous interventions, we saw detailed recordings of this, along with effective care planning, regular reviews and MDT discussion.

Ward staff and advocacy continued to support individuals with their rights, and we saw evidence of this in individual files, where information was accessible and in pictorial format. Some individuals we spoke with were able to tell us about their rights and how they had been supported by advocacy and solicitors and were aware of the mental health tribunal system.

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. Where specified person restrictions were in place under the Mental Health Act, we found that all paperwork was in order. We discussed one case with the SCN of Loirston Ward and the consultant psychiatrist, as we felt on reviewing the specified person paperwork and the care plan that there was confusion around some restrictions and further clarity was required.

When we are reviewing individual files, we looked 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, the staff and advocacy had supported them to do so and that this was discussed at regular intervals, at MDT and CPA meetings. Where a person was assessed as unable to make an advance statement, we found this had been recorded in the files.

We wanted to follow up on our previous recommendation regarding the need for a seclusion policy. This had also been a recommendation from our visit in 2019 when the wards were in Elmwood Hospital and seclusion had been applied. We received an action plan from our visit last year about how the service had planned to meet this recommendation. We were disappointed to hear that the service had still not devised a policy. Managers told us that work was still being done on this and that further work was still required. Although we were told that seclusion had not been used for any individuals since our last visit, we will therefore repeat our previous recommendation.

Recommendation 1:
Senior managers must devise a seclusion policy as a priority and ensure this policy is implemented across the service.

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

Both wards had dedicated OT input that provided assessment-focused activities, and the OT staff continued to be involved in the assessments that were pertinent to individuals' discharge planning and supported their re-integration back to the community. Nursing and other ward-based staff also provided activities as often the person required more than one staff member to escort them in the community.

In Strathbeg Ward, we saw that each person had a weekly planner in place and individuals told us about their activities, including work placements. We heard that most of the activities took place in the community or in the recovery resource centre, which is based in Royal Cornhill Hospital. Individuals told us that they liked being out in the community and enjoyed activities such as bowling, cinema, shopping and attending concerts.

We noted that there was detailed recording in the case notes of activities that were taking place and that there was a regular review of these with individuals. Both wards continued to have access to vehicles to support community activities.

Each ward had a dedicated activity area that included gym equipment, TV's/game consoles and Strathbeg Ward had a pool table that individuals enjoyed.

We had heard on our last visit to Loirston Ward that there was a plan to recruit an activity nurse who would be solely activity focussed, but were told that this did not happen. We were told that the level of OT provision across both wards was good and the collaborative working between the nursing and OT staff provided the level of individual activity that was required.

The SCN told us that in Loirston Ward a breakfast group had commenced, which enabled individuals to make their own breakfast from items that the staff had placed in the dining area. There was a pictorial chart on display to support individuals with this task. We were told that this was working well and enabled individuals to maintain skills whilst being in hospital; a similar lunch group was planned.

Where some individuals had a commissioned provider from the Health and Social Care Partnership (HSCP), we were told that the social care staff continued to provide the support, where appropriate, enabling individuals to continue with their community activities while in hospital, which was positive to hear for continuity purposes.

We felt that both wards had a real focus on activity provision that was built into individuals' care and treatment. Through staff consistently supporting people with their routine and structure, and in applying their positive behavioural support plans, we heard that this had led to the reduction of the need for 'as required' medication and restraint, which ultimately had better outcome for individuals.

The physical environment

The two wards moved to the main site at Royal Cornhill Hospital in April 2020. Both wards moved into what was formerly older adult wards.

Both had a mixture of single bedrooms with ensuite toilets and dormitory style accommodation. Due to the complexity of needs for individuals across both wards, the dormitories were often used for one individual, as risks associated with sharing was not appropriate. We saw how the staff had adapted areas in the ward and rooms to best meet the needs of the individuals.

Each single room had floor to ceiling glass windows that looked out to the ward corridor, providing a lack of privacy. The single rooms had sliding doors to gain access to the room and in Strathbeg Ward, there was a door to the ensuite toilet, but in Loirston Ward, all doors had been removed and had been replaced with a shower curtain. We felt this created a further lack of dignity for individuals while using these facilities.

Both wards had one shower room and one bathroom each for all individuals to use. The bath in each ward was more appropriate for the older adult group that used to occupy the wards and had not been changed to meet the needs of people with a diagnosis of learning disability and/or autism and complex needs, such as sensory needs.

We again heard from staff and individuals that the lack of showering/bathroom facilities caused difficulties, as people were often having to wait to access those facilities. Depending on who was in the ward and what their specific needs were, waiting for such facilities could lead to escalating behaviours and cause individual distress. We were told that the bath in Loirston Ward had been out of order for several months and only recently the specific part had been purchased and delivered. This was still waiting to be fixed on the day of our visit.

We heard about the heat in the wards from individuals and staff, and the lack of fresh air, as the windows did not open across both wards. This was more evident in Loirston Ward on the day of our visit, where standing fans had been positioned throughout the ward.

There was floor covering on both wards where repair was needed, as tape was covering this.

Loirston Ward now has a pantry cupboard where individuals are able to make tea and coffee and Strathbeg Ward had set up some kitchen equipment in one of the dormitories.

On previous visits we had heard of staff being invested in trying to make improvements to the ward environments to support individuals' rehabilitation. We

were able to see some of these changes on the day of this visit, however we appreciate there was only so much the staff team could do to better the environment and they all recognised this.

We were informed that the service was awarded some funds to develop a sensory room and we heard about the planning of this on Loirston Ward. The ward had a specific room we saw on last year's visit that was hoped to develop into a sensory room, so it was good to hear more about this and how the improvements have been identified by the individuals in the ward.

Both wards were spacious, with ample seating/dining areas. Although there was some signage around the wards to support individuals with orientation, this was limited. We saw that some new furniture had been purchased for the dining and sitting areas however, we were told that the wards tended to get a few new chairs at a time as opposed to changing all at once. Strathbeg Ward had access to a garden that had a large fence separating it from another ward. We were told that individuals did use the garden however, the garden area needed some maintenance.

We had previously been told that a functionality assessment was undertaken for both wards not long after the service moved from Elmwood Hospital to Royal Cornhill Hospital. We have continued to ask for updates regarding the progress of this assessment, and the works that have been identified as a result of this and unfortunately, we did not receive a response, and the report could not be found. We made a recommendation after last year's visit for a functionality assessment to be undertaken on both wards. This would identify areas for improvement in order to meet the needs of people with a diagnosis of learning disability and/or autism. We received an action plan as to how the service was going to meet this recommendation. However, we were concerned that this recommendation had not been met, as this action had not been met after the previous report's recommendations.

Recommendation 2:
Senior managers must ensure that environmental assessments of both wards are undertaken as soon as possible in order to identify and plan works to improve the environment, so that it meets the needs of individuals with a diagnosis of learning disability and/or autism.

Summary of recommendations

Recommendation 1:
Senior managers must devise a seclusion policy as a priority and ensure this policy is implemented across the service.

Recommendation 2:
Senior managers must ensure that environmental assessments of both wards are undertaken as soon as possible in order to identify and plan works to improve the environment, so that it meets the needs of individuals with a diagnosis of learning disability and/or autism.

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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