



## **Mental Welfare Commission for Scotland**

### **Report on announced visit to:**

Skene Ward, Royal Cornhill Hospital, Cornhill Road, Aberdeen  
AB25 2ZH

**Date of visit:** 22 November 2022

## **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.

Skene ward is a 16-bedded, mixed-sex ward for patients who have a diagnosis of dementia and experience a level of stress and distress behaviours. On the day of the visit there were 16 patients in the ward. We last visited this service on 28 September 2021 and made a recommendation about access to the outdoor garden.

We asked managers to provide us with an update regarding the older people's service review that we were told about during our last visit. We heard that a transformation team had been set up to review the dementia pathway, following ward closures in the dementia services for older adults in Royal Cornhill Hospital. The Commission had also been made aware of a recent closure of a community dementia ward in the Aberdeenshire area, and of the closure of some care home placements across the area. Managers told us about the ongoing challenges and pressures due to the reduction in the bed provision in the in-patient dementia services, as well as the impact of fewer care placements in the community.

Managers explained that the review had been put on hold during the Covid-19 pandemic, however it was due to recommence. We asked managers for an update and were told that there had not been much progress, although now that the transformation team had set up, there were workshops dates planned for the Health and Social Care Partnerships (HSCP) to review the dementia pathway across in-patient and community. We will continue to ask for updates from senior managers about the review, its progress and outcomes.

Managers told us about the ongoing staffing challenges in trying to fill nursing vacancies and recognised that this was a national issue. We were told about the continued proactive efforts to recruit staff and how the ward had recruited five health care support workers to the unit since our last visit. Managers told us that they continued to have a daily huddle to discuss bed pressures and staffing issues across the service and there continues to be a recruitment drive to fill vacant posts.

## **Who we met with**

Prior to the visit, we held a virtual meeting with the senior charge nurse (SCN) and consultant psychiatrist.

On the day of the visit we spoke with the SCN, consultant psychiatrist, business support manager, clinical nurse manager (CNM) and ward-based nursing staff. Contact was also made with the service manager.

During our visit, we introduced ourselves and chatted with patients on the ward. We were not able to have in-depth conversations with all patients, because of the progression of their illness, however most patients appeared relaxed and content in the ward environment.

We reviewed the care of six patients and also met with, or spoke to seven relatives.

## **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 mostly positive; they told us that they felt involved in the care and treatment of their relative and that the communication was excellent from the doctor, after the multi-disciplinary (MDT) meetings. We heard from them that they were consulted about all aspects of their relatives' care, including medication changes. Some relatives described staff as caring and kind; others told us that staff had a real sense of commitment and knowledge about working with their loved ones. They had a good understanding of the routine of the ward following their relative's admission, which they told us was helpful and they knew how, and with whom, to raise any issues of concerns or worries that they had about their relatives care and treatment. We heard that relatives often find that an admission of their loved one to hospital can be a stressful and worrying time, due to the separation. We were aware that there had been some issues with laundry that the service was trying to resolve and a few relatives also mentioned the difficulty of access to the outdoor garden space. We followed up on an individual case where some concerns were shared with us.

Relatives told us that they enjoyed visiting the ward and were made to feel welcome. Some relatives told us that visiting and spending time on the ward also provided them with the opportunity to talk to other relatives and carers who were perhaps experiencing similar situations.

Throughout the visit we saw caring and supportive interactions between staff and patients. The ward had a sense of calm and the staff we spoke with knew the patients well. We saw positive interactions between the staff and patients and where some patients were showing signs of stress and distress behaviours, the staff responded promptly to the patients. During our visit last year there was a strong commitment and enthusiasm from the staff team towards meeting the patients' needs and this is what we found on this visit.

### **Care plans**

The care plans continued to be in paper format and were easy to navigate. When we last visited the ward we found care plans that were detailed, person-centred, and covered a wide range of holistic needs, included specific interventions for stress and distress behaviours. We found the same on this occasion and saw that the standard of care planning had continued to be maintained at this level, which was positive. We were able to see daily reviews of each care plan in the nurses' continuation notes and evidence that care plans had been updated following evaluation. We saw evidence where relatives and proxy decision makers had signed the care plan or there was a recording in the notes to say that the relative had agreed and were satisfied with current plan. There were detailed one-to-one interventions recorded by staff, and there was a link between therapeutic activities and the use of non-pharmacological interventions that was evident throughout the patients' files.

We found mental health assessments that were detailed and contained good life history information. These provided information on patient needs, risk assessments and risk management plans. We saw evidence that these were reviewed and updated where necessary.

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)**

The ward had good support from a wide range of professionals such as a consultant psychiatrist, psychology, occupational therapy (OT) and a GP, who provided input regarding patients' physical care. We found there was good attention to the link between physical and mental health care in the patient records. We were also told that patients had good access to allied health professionals, and we saw a separate section in patients' files where referrals had been made to other services, such as physiotherapy and dietetics.

The MDT meetings continued to be held weekly and the ward has had regular input from pharmacy at these meetings. We saw clear recordings in patient files, as to how relatives were kept updated following the MDT meeting. Feedback from relatives was positive about this contact and we felt this provided them with the opportunity to input to the MDT.

We reviewed MDT meeting minutes and were able to see a clear multi-agency approach to patient care. The minutes recorded who was present at the meeting, the discussion held, along with the actions and outcomes. Where a patient was assessed as being medically fit for discharge, there was a lack of detail about the progress of this, however we found information relating to communication with social workers and care managers; this was in the communication section of the file, which was helpful. This section in the care notes clearly evidenced who was involved in the patient's care. We suggested to the SCN that staff, where appropriate, should make reference to this section of the MDT meeting record.

We were told that discharge planning meetings continued to take place when required, or at specific times throughout each patient's journey. We heard of progress plans for patients who had been assessed as medically fit for discharge, however we were told that some patients names are placed on the delayed transfer of care list and not always on the hospital's delayed discharge list.

Managers and ward staff we met with were unclear regarding the difference between these lists. We had further discussions on the day about this as we wanted to know more detail about the delayed transfer of care list and why some patients would be placed on this list and not the delayed discharge list. There appeared to be confusion about the lists and of the criteria therefore we were concerned about this lack of clarity and we will write to the senior managers of NHS Grampian.

#### **Recommendation 1:**

Managers should ensure that there is clearly defined protocol for any patients who are medically fit to be discharged and whose discharge from the hospital is delayed.

### **Use of mental health and incapacity legislation**

On the day of our visit nine patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Mental Health Act paperwork in the records was 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. Certificates authorising treatment forms (T3) under the Mental Health Act were in place where required, and corresponded with the prescribed medication. We found that all T3 certificates were available and up-to-date.

For patients who were given medication covertly, we saw detailed covert medication pathways in files, which were appropriately reviewed.

The Commission has produced good practice guidance on the use of covert medication at: <https://www.mwscot.org.uk/node/492>

For patients who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act 2000, 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 must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act, and the doctor must also consult with any appointed legal proxy decision maker and record this on the form. Section 47 certificates were all in good order for each patient, along with accompanying detailed treatment plans that were in line with the AWI code of practice for medical practitioners.

On reviewing each patient's notes, we were pleased to see that staff had recorded specific legal orders that patients were subject to under AWI legislation; this made clear the legal authority that was in place. However there were a few entries which simply recorded "AWIA in place". We brought this to the attention of the SCN on the day as we considered this lack of detail and clarity could lead to confusion amongst clinical staff.

The Scottish Government produced a revised policy on DNACPR in 2016: <http://www.gov.scot/Resource/0050/00504976.pdf>

This policy makes it clear that where an adult cannot consent, and there is 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 whatever steps are possible to establish the wishes of the patient. From the files that we reviewed, we found that DNACPR forms had clearly recorded where proxy decision makers and families had been consulted.

## **Rights and restrictions**

The door to the ward was locked and we saw individual risk assessments that identified patients who due to their vulnerability and progression of their illness, would be at risk if the door were opened. We noted that there was no locked door policy displayed on the door, but were aware that NHS Grampian does have a policy in place. The SCN agreed to ensure the policy is displayed so patients and visitors are aware of their rights, including access to and from the ward.

The ward had good links with advocacy service, who were based in the hospital and we were able to see involvement of advocacy services when reviewing patient files.

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.mwscot.org.uk/law-and-rights/rights-mind>

## **Activity and occupation**

The ward continued to have a therapeutic assistant, who provided activities on the ward from Monday to Thursday, and health care support workers who also provided activities during afternoons and evenings. A weekly timetable of group activities was displayed on the wall in the ward, and we were able to see that the ward had developed separate zones in the lounge to provide spaces for small group activities, such as a reminiscence group, arts and craft and music. On the day of our visit we saw a reminiscence group taking place and patients had the opportunity to join in. Some patients were watching programmes on the television, whilst others were wandering in the corridor.

We were told that staff also co-ordinated themed events and on the day of this visit, a themed event had been organised which we saw patients participating in and enjoying. One-to-one and group activities were recorded in the patients' files along with a record of the benefit gained through activity for the patient. The ward had a clear focus on the importance of activities for people with dementia in managing their levels of stress/distress behaviours, and this was evident throughout the patients' notes.

The ward also used reminiscence interactive therapy activities (RITA) technology that augmented the care delivered to older people living with dementia. We saw good life story work in the files that linked to individual activity care plans.

## **The physical environment**

The layout of the ward consisted of five single rooms and three shared dormitories. There was a lounge area and a separate dining area for the patients; both were bright and spacious. The ward had not been purposely built for patients with dementia, however we saw where there had been continued efforts made to soften the public rooms, and found that the environment offered a warm and therapeutic setting for patients. We saw where smaller therapeutic areas had been developed in the lounge and we heard of other plans to improve the ward. We saw that where patients had their own rooms, that they had brought in some of their own belongings, and other patients had personalised boxes in their rooms or bedside units which had been put in since our last visit.

We heard from staff and some relatives about issues with the shower in the ward and that patients had not been able to use this. We followed this up on the day with managers as the ward only had one bath. Managers told us that there had been ongoing problems with the shower, including water pressure and since the shower head had been changed, it had slightly improved. We looked at the shower during our visit, and the pressure at that time seemed fine, but we were told that this can be intermittent throughout the day. Managers told us that there continued to be ongoing work and were investigating how to resolve this matter, and all relatives had been kept up-to-date and were informed in writing.

We wanted to follow up on our recommendation from our last visit with regards to patients having access to a well maintained outdoor space; we had found that the garden area at that time was in a state of disrepair. Skene ward was situated upstairs and was the only dementia

ward in Royal Cornhill Hospital, following the closure of the other two wards. Staff told us they could no longer access the garden as easily as they once could and we also heard from some relatives that they had been able to visit the garden during the summer months, however access was not easy. However, we were told that some work had been done to improve the outdoor space, and that the SCN was awaiting approval from senior managers regarding further work to be carried out on the garden area.

Outdoor access is important for all patients and can improve the wellbeing of those who experience stress and distress behaviours. It is therefore imperative that accessibility of outdoor space remains a priority across older people's in-patient services, and especially for those patients with a diagnosis of dementia. We would expect the older people's transformation group to ensure this is fully explored, and taken into account when decisions are being made regarding any future changes to older people's in-patient services.

## **Summary of recommendations**

### **Recommendation 1:**

Managers should ensure that there is clearly defined protocol for any patients who are medically fit to be discharged and whose discharge from the hospital is delayed.

### **Service response to recommendations**

The Commission requires a response to this recommendation 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.

### **Contact details**

The Mental Welfare Commission for Scotland  
Thistle House  
91 Haymarket Terrace

Edinburgh  
EH12 5HE

Tel: 0131 313 8777  
Fax: 0131 313 8778  
Freephone: 0800 389 6809  
[mwc.enquiries@nhs.scot](mailto:mwc.enquiries@nhs.scot)  
[www.mwcscot.org.uk](http://www.mwcscot.org.uk)



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