



Mental Welfare Commission for Scotland

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

Date of visit: 24 October 2023

Where we visited

Skene Ward is a 16-bedded, mixed-sex ward for individuals who have a diagnosis of dementia and can experience a level of stress and distress behaviours; the ward is on the main Royal Cornhill Hospital site.

The ward offers single room and dormitory accommodation for 16 individuals, and we heard from managers that there were also two surge beds in the ward, to manage any crisis admissions. On the day of the visit, there were 17 individuals in the ward.

We last visited this service on 22 November 2022 and made a recommendation with regards to a protocol for patients who are medically fit to be discharged.

Managers told us that they continued to have a daily huddle to discuss bed pressures, admissions and discharges, along with staffing numbers to ensure safe delivery of care.

Who we met with

Prior to the visit, we held a virtual meeting with the senior charge nurse (SCN) and consultant psychiatrist and on the day of the visit, in addition to them, we also spoke to other ward-based staff.

We reviewed five individuals' care and treatment and also met with/or spoke with eight sets of relatives/carers. We linked in with the local advocacy service, who made themselves available on the day of the visit.

Commission visitors

Tracey Ferguson, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

We heard that individuals were either admitted to the ward for assessment purposes from their home, or from their community care placement, and that each individual was at a different stage of their journey. Some had been admitted more recently and others had been in the ward for a longer period.

Due to the varying degrees of cognitive impairment, for some individuals, they required a more intense level of support from nursing staff, which included assistance with personal care, mobility and dietary requirements. While the majority of individuals were older adults, there were a number of individuals who had developed dementia at a younger age. The ward-based team recognised this could be an extremely difficult time for families and we heard from staff as to how they made every effort to ensure individuals and their families were supported.

During our visit, we introduced ourselves and chatted with most individuals, however we were not able to have detailed conversations, because of the progression of their illness. Most individuals appeared relaxed and content in the ward environment, and where some were experiencing distress, we observed staff responding and interacting with them in a warm and caring manner. We saw staff taking their time with their communication with individuals. There was a sense of calmness; staff we spoke to acknowledged that it was important that individuals felt safe and secure, considering how symptoms of dementia can sometimes cause feelings of disorientation and distress.

The feedback from relatives was positive about the staff team. Relatives described staff as “wonderful”, “compassionate”, “brilliant”, and “experienced”. A few relatives told us that they found the whole experience of an admission to the ward as being positive, and felt the ward was welcoming, and that communication with all the multidisciplinary team (MDT) and ward based staff was very good. Another relative told us that there had been significant benefits with the assessment process, and had noticed a positive change in their relative since the introduction of medication. One relative told us that they were so grateful for all the support, in particular, where attention was paid to their loved one’s personal care and appearance.

Some relatives told us that they had seen the care plans, and others told us that they knew they were available.

A few relatives raised issues with the current environment, particularly around sharing dormitories, and how the ward admitted both male and females. We also heard how the current environment was not dementia-friendly and that there had been issues in one bedroom where there had been a water leak in the ceiling, resulting in an individual having to move, causing upset and further distress.

Relatives told us that they knew how, and with whom, to raise any issues, concerns or worries that they had about their relatives care and treatment. We heard that visiting and spending time on the ward also provided relatives with the opportunity to talk to other relatives and carers who were perhaps experiencing similar situations.

We followed up on an individual case where some concerns were shared with us. These related to aspects of care and treatment that were not as positive, such as communication and treatment. We raised these with the senior managers at the end of the day in order for them to address these.

During our previous visits we recognised that there was a strong commitment and enthusiasm, from the multidisciplinary and staff team. Along with their extensive knowledge base used to meet the individual's needs, we again found this to be the case on this visit. Some relatives told us that they were anxious about their loved ones having to move on from the ward, as this was the most settled they had seen their relative, and in their view, this staff team knew how to care for people with dementia.

Care plans

The care plans continued to be in paper format and were easy to navigate in individuals' files. On last year's visit we found care plans that were detailed, person-centred, and covered a wide range of holistic needs, included specific interventions for stress and distressed behaviours. We were pleased to find the same on this occasion, and noted that the standard of care planning had been maintained at this level, which was good to see. The SCN told us about the piloting of new care plan documentation that had come from a working group, which had been devised to improve care planning documentation and processes. We saw the new documentation, and were aware that nursing staff were in the process of changing over all the care plans to this new documentation. As this is a pilot, we look forward to hearing how this progresses.

We were able to see daily reviews of each care plan in the continuation notes, and evidence that care plans had been updated following evaluation. Most of the care plan evaluations provided a good level of detail, apart from a few that we highlighted to the SCN. We saw evidence of 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 the current plan; however, there were a few care plans and files where there was no recording of this.

We heard that the new care planning group had also been tasked with updating the audit documentation and would therefore suggest, if this has not already been done, to ensure that the audit documentation captures patient/carer participation.

We found that the level of detail in the one-to-one recordings by staff was exemplary. There was a clear link between therapeutic activities and the use of non-pharmacological interventions was evident throughout the individual notes.

We found mental health assessments that were detailed, and contained good life history information that provided an update regarding individual needs, including an updated risk assessment and risk management plan. We saw evidence that these were reviewed and updated where necessary. We saw a one-page profile in each file, that was detailed and provided a summary of what was important to that individual, and how they wanted or needed to be supported, which was positive.

Multidisciplinary team (MDT)

The ward continues to have a robust MDT in place that includes; consultant psychiatrist, psychology, occupational therapy (OT) and input from a GP, who provides physical healthcare for each individual. We found there was good evidence of physical and mental health care monitoring and ongoing reviews and discussions taking place between the MDT. Individuals with dementia cannot at times verbalise what may be wrong with them from a physical point of view, but may display this in other ways. Therefore, close monitoring and supervision of individual's health is required in order that specific signs and symptoms are picked up swiftly to address needs, ensuring consultation with relatives.

The ward continued to have good access to allied health professionals for individuals' care and treatment and we saw a separate section in the files where referrals had been made to other services such as physiotherapy, dietetics and speech and language (SALT).

The MDT meetings are held weekly and the ward has regular input from pharmacy. We saw a record of the MDT meetings in individual files, along with a separate entry in the nursing and medical records about who attended the meeting along with recorded actions/updates. The ward had a personalised approach to the MDT meeting for relatives, where some relatives told us that they attended, and other told us that they wanted an update following the meeting. One relative told us that having a Microsoft Teams meeting via video link was helpful, as they lived far away and were not able to always attend face-to-face. We saw recordings of other meetings taking place, such as those relating to discharge planning with social work involvement, or family meetings with the consultant psychiatrist. All of the relatives/carers that we spoke with were aware of the current stage of their relatives care and treatment and what had been agreed at the MDT meetings. The SCN told us that the presence of social work at meetings could be variable and they were looking at ways to improve relations, communication and ensuring that discharge planning was effective. The ward was planning to commence a regular meeting with the social work teams to exchange communication and receive regular updates with discharge planning.

We wanted to follow up on our last recommendation where there was lack of clarity about reporting procedures for individuals who were medically fit for discharge. Managers told us there had been a protocol developed by inpatient services, and that individuals who were fit for discharge from Skene Ward were placed on the delayed discharge list. We were told that there were seven individuals who were ready to move on from hospital, that five individuals had been placed on the delayed discharge list, and that a further two had been placed on the delay transfer of care list, as they had been identified as still requiring hospital care and a transfer was being considered. We were pleased that there had been discussions, that a protocol had been devised and that the MDT were clear on reporting purposes. However, the Commission was aware that this was not the case across other wards in the Royal Cornhill site or in the health and social care partnership (HSCP), and has raised this with senior managers following other local visits. We had been told that the delayed transfer of care list had been operating at Royal Cornhill since around 2018 and only in Royal Cornhill Hospital. Senior managers had told us that there was work ongoing to improve processes and in understanding the systems for all staff across the HSCP and inpatient services.

Use of mental health and incapacity legislation

On the day of our visit 10 individuals were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (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, were readily available, up-to-date and corresponded to the medication being prescribed.

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

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act and the doctor must also consult with any appointed legal proxy decision maker and record this on the form. On our last visit, we found exemplary s47 certificates along with the treatment plans completed in accordance with the AWI Act code for medical practitioners; we found this to be the case again on this visit.

On reviewing each individual's notes, we were pleased to see that staff had, in most cases, recorded specific legal orders that the patients were subject to under AWI Act legislation; this made it clear regarding the legal authority that was in place. However, there were a few entries which simply recorded "AWIA in place". We brought this to the SCN attention on the day and suggested that this information could be captured in the audit tool if it had not already been.

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 has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as take what 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

Skene Ward had a locked door policy in place and our view is that this policy should be displayed. The SCN ensured it was displayed on the door during our visit, but we were disappointed to find that it was not displayed after we had made reference to this in our last report.

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 individual 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.mwcscot.org.uk/law-and-rights/rights-mind>

Activity and occupation

The ward continued to have a therapeutic assistant who provided activities to the ward from Monday to Thursday, and health care support workers who also provided activities during afternoon and evenings. A weekly timetable of group activities was displayed on the wall in the ward, and there were separate zones in the lounge to provide spaces for small group activities, such as reminiscence group, arts and craft and music. 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 which linked to individual activity care plans, along with recording of one-to-one and group activities in individual files, highlighting the benefit of the activity for the individual. We were told that the ward continued to bring in outside activities such as therapist.

On our last visit, we found that the ward had a clear focus on the importance of activities for people with dementia in managing their levels of stress/distress behaviours, and we were pleased to see that this was evident throughout the files we reviewed on this visit.

The physical environment

The ward accommodation consisted of five single en-suite rooms and three shared dormitories, along with communal lounge and dining areas that were bright and spacious for individuals to move around. We saw that some individuals had brought in personal items to make their room or bed space more personalised. The SCN told us that there tended to be four individuals based in a dormitory however, this could increase depending on demand. More recently we had heard from staff and a relative about a leakage in the roof of one of the side rooms, which had resulted in the single room no longer being in use. The SCN told us that the leak had previously been fixed, however it had worsened during the recent storm. The SCN and clinical nurse manager informed us that there was a priority to get the issue fixed as the room was required, given that there were only five single rooms in the ward. We saw the room which had a damp odour. Managers told us that there continued to be ongoing work to resolve the matter.

This ward had not been purposely built for patients with dementia and we noted on our previous visits that there had been continued efforts to enhance the environment, and improve it for the patient group and for the staff who were supporting them. We heard from staff and relatives that the current layout and environment could present challenges when supporting individuals, who were displaying stress/distress behaviours.

Skene Ward was situated upstairs and was the only dementia ward currently in Royal Cornhill Hospital, following the closure of the other two specialist wards. The ward had access to a downstairs garden and we heard how this was accessed until recently; we also heard that there had been issues with the lift breaking down, which had an impact on access.

We asked managers to provide us with an update about the older people's review that was being undertaken. We were told there had been no progress with the review since our last visit due to other priorities across the health board. This was disappointing to hear given that we had previously been told about the ongoing challenges and pressures due to the reduction in the bed provision in the inpatient dementia services, as well as the impact of there being less care placements available in the community, resulting in individuals being in hospital for longer periods than necessary. We will continue to link in with managers about the review.

Service response to recommendations

The Commission made no recommendations; therefore, no response is required.

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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