Mental Welfare Commission for Scotland

Report on announced visit to:
Huntly, Fraser, Dunnottar, Fyvie Wards, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 12 and 13 February 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

We visited the four adult acute mental health psychiatric admission wards that are based in the Royal Cornhill Hospital; Huntly, Fraser, Dunnottar and Fyvie.

Each ward has a bed capacity of 20, that included two surge beds in each ward. Managers told us that due to clinical demand the surge beds were used frequently. Each ward admitted individuals of mixed gender, and all wards offered a mixture of single rooms and dormitory accommodation. On the day of this visit, all four wards were at full capacity, with all surge beds in use.

Huntly Ward had a catchment area predominantly that covered Aberdeen City, while Fraser Ward had a catchment area that covered Aberdeenshire. Dunnottar Ward covered Aberdeen City, Shetland and Ministry of Defence. Fyvie Ward had individuals admitted from Orkney, Aberdeenshire, and Aberdeen City.

We last visited this service in January 2024 on an announced visit and made recommendations about care planning, multidisciplinary team meetings, risk assessments and management plans, Part 16 Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act) treatment certificates, training needs around Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) legislation, specified person legislation and maintenance repairs across the wards.

In response we received a detailed action plan from the service. The Commission provided further feedback to the service upon receipt of the action plan and points for the service to consider.

On the day of this visit, we wanted to meet with individuals who were receiving care and treatment on the wards, speak with their relatives, follow up on the previous recommendations and hear about the boarding situation. On our visit last year we found that there was a significant number of individuals boarding out with their catchment area and boarding out with general adult psychiatric (GAP) services. We were also aware on our visit last year that there were changes between inpatient catchment areas and the community mental health teams which had had an impact on the situation.

Managers told us that as the alignment with the wards and the community teams had been in place for a while, the situation had improved from last year's visits. However, there were times that people still had to be boarded to another GAP ward, due to no bed availability in their catchment area. We were told that the situation had improved, particularly with people boarded out to wards out with GAP services.

Managers told us that the intention was always to transfer individuals to their aligned ward when a bed became available, and we found this to be the case on our visit. We had previously requested a copy of the boarding protocol, and we had been

provided with an update of the progress. The relevant lead nurse for the service agreed to provide a copy to the Commission once the protocol had been through governance processes.

Although we were told that the boarding situation was not as extreme as last year, nursing staff, medical staff and managers told us about the ongoing challenges of individuals boarding out of their ward, particularly around reviewing each individual's care. All staff and managers told us that there continued to be spells of increased crisis admissions from the community, with staff telling us that the continued level of clinical acuity was still significant at times, which placed a demand on beds and staffing levels. Staff and managers told us that the introduction of the new electronic recording system had helped with the continuity and transferring of individuals' care, as all professionals were now recording daily in the electronic system, TRAKCare.

We had received a few calls to our duty advice line from individuals and carers about their experiences on these wards, where some people, including professionals had raised concerns around discharge planning and involvement. We had also been notified of some significant incidents and were aware that the service was carrying out adverse event reviews (AER). The Commission will continue to link in with senior managers from Grampian Health Board and relevant managers from the health and social care partnership (HSCP) about these reviews.

Managers told us that they have continued with a daily huddle to discuss bed pressures, admissions, and discharges, along with staffing numbers to ensure safe delivery of care. At this meeting there would be a discussion as to which individuals may be suitable to be boarded to another ward. The senior charge nurses (SCN's) and consultant psychiatrists told us that they would usually be involved in this discussion, but not always if this was out-of-hours.

Who we met with

Prior to the visit, we held a Microsoft Teams meeting with the SCNs, inpatient clinical lead, service manager, nurse manager, psychologist, occupational therapist (OT) and pharmacist.

On the day of the visit, we spoke with the SCNs, other ward-based nursing staff, medical staff and consultant psychiatrists. We also met with the clinical psychologist and lead pharmacist.

We met with 34 individuals across the four wards and reviewed the care and treatment of 21 individuals. We also spoke with five relatives from Dunnottar and Huntly Wards.

In addition, we met with the advocacy service and our engagement and participation officer attended two community meeting that were held in Dunnottar and Fraser Wards on the days of the visit.

Commission visitors

Tracey Ferguson, social work officer

Claire Lamza, executive director (nursing)

Dr Sheena Jones, consultant psychiatrist

Denise McLellan, nursing officer

Sandra Rae, social work officer

Graham Morgan, engagement and participation officer (lived experience)

Jenn McIntosh, student nurse

What people told us and what we found

We found across the four wards, individuals were at different stages of their recovery, with most individuals having been recently admitted to the wards, and some who had been in the wards for a longer period.

There were a significant number of individuals who were detained under the Mental Health Act across all the wards, which was similar to last year's visit, and due to the increased levels of risk and acuity of mental ill health, some individuals had been placed on continuous intervention and required a higher level of staffing intervention.

We met with several individuals across the wards where it was difficult to have detailed conversations with them due to the acuity of their illness. However, we met with others who were at different stages and able to have more detailed conversations about their experiences.

We met with several people who told us that they had been admitted to one ward and had recently been transferred to the ward that was for their geographical area. Some individuals told us that they would have preferred to remain on the ward where they were admitted to, and others could not tell us why they were moved. Individuals who had been in more than one ward were keen to tell us about their different experiences across the wards and what impact this had had on their recovery.

Individuals that we spoke with in Fraser Ward described staff as "fine", "helpful" and "supportive". One individual told us that the "nurses had been the best in their experience and were excellent". One individual told us that they found the staff approachable, and that staff were always around to talk with. A few individuals commented that the ward was like a "prison", as they never got out. While some individuals told us that they felt safe on the ward, some told us that they did not, and this would often depend on who else was in the ward at the same time.

We heard from quite a few people that they felt involved in their care and treatment, while others did not feel so involved. We heard from several people about the difficulty of getting off the ward to smoke. One individual told us that there should be more staff for escorted leave as people could often wait for hours to get off the ward.

One individual who was in a shared dormitory told us "sharing a room with others who were also unwell, was the very opposite of trauma informed care". We gained the sense that individuals knew about their rights, which they were able to explain to us and had a good understanding. Where individuals expressed their unhappiness at being on the ward, we ensured that there was an appropriate legal framework in place, along with regular review.

We received positive feedback in Huntly Ward about the staffing, where some described staffing as “helpful”, “approachable” and “good”. One individual described the ward as a “nice place”, whilst another told us that they had “been treated well”. Another person told us that the psychiatrist and psychologist made appointment cards which was good, as this informed them as to when they were going to be seen. While a few told us they felt involved in their care and treatment, including care planning, other people’s experience differed, where they did not feel as involved. A few individuals told us that they managed to get off the ward regularly to smoke.

We had mixed feedback about the care of those individuals we met in Fyvie Ward. We heard from a number of individuals that “there’s nothing to do” on the ward, that staffing could be a problem, especially where there were continuous observations required and that there were different approaches taken by different staff. We heard that in Fyvie Ward “the nurses have more time and are more caring” than some individuals had experienced in other wards although we also heard that it could be “hard to get a hold of them” ; some were described as “wonderful” or a “shining star”. We heard from some about their meetings with the doctor and other professionals. One individual described the multidisciplinary meeting as “daunting” due to lots of people present, whereas another individual told us that they felt decisions had already been made before they went to the meeting. One individual told us that they found it helpful when a staff member sat with them and explained about their medication, so they were then able to recognise the benefits, and this helped them to understand better. We heard from several individuals that coming into hospital had not made them feel any better, that Fyvie Ward was “strict” and that they “had no idea of what’s going on” with their care. For some, they thought there was a lack of training, specifically in relation to individuals with an eating disorder.

In Dunnottar Ward one person described the staff as “helpful”, whilst another individual described the staff as “excellent”. While some told us that they felt safe, some told us that they did not, due to the noise levels and aggression displayed by others on the ward. A few individuals told us that people were allowed to play loud music at night, which disturbed them. Most people told us that they found it difficult to get off the ward to smoke. One individual described their admission to Dunnottar Ward as being the “best stay” out of other admissions that they had. Some told us that they had been involved in developing their care plans, whereas others told us that they had not seen or been involved in their care plan. One individual described a positive experience and that regularly going through their care plan aided their recovery. One individual told us that they had regular meaningful discussions with their doctor and felt involved in decisions about their care and treatment. However, this was not the experience of some others, who told us that they continued to request to meet with the doctor, and were often left not knowing when this would happen.

We followed up on several cases throughout the visit, particularly where there were concerns raised with us. We provided feedback on the day to the SCNs and had a follow up meeting with managers where further concerns were shared.

We asked individuals about the catering to the ward and the views were variable. Some individuals told us that it would be better if there were healthier options and more attention given to diet and its impact on mental health. We heard comments about the food, such as “it’s not too bad”, “there’s good variety”, “it’s really good”, and “it’s mushy”. A few people told us they would like more vegetarian options. Where individuals had specific dietary requirements, we were told that the catering department provides these. We did speak further to the SCN on Dunnottar Ward where specific issues were raised with us about an individual’s diet.

There were some individuals who commented on the different approaches at mealtimes, across the wards. One individual told us that on Dunnottar Ward people lined up for their meals, whereas on another ward, everyone sat down at the table and staff asked people for their preference.

We got the impression that people did not always know the routine and structure of the ward and what to expect when first admitted, which is similar to what we heard from relatives. On our visit last year, we heard that some wards had leaflets, and some had written information on notice boards.

The feedback we received from relatives about staffing was generally good. However, relatives told us that communication was difficult, and they were often not kept informed or up-to-date about their relatives’ care and treatment, especially when people had moved wards. Relatives told us that they struggled with getting updates and while they understood that individuals may not want information shared, they often did not feel listened to.

The issue of smoking came up from the majority of people we spoke with across the four wards. People shared their experiences, telling us that it often depended on the ward you were in, as to how often you could get off the ward to smoke. Individuals who did not smoke told us that the staff’s time could be taken up with taking people out for their smoke break, and they did not feel this was a good use of nursing time. Several people commented that it was difficult, as there was no garden area to smoke and that individuals did not know when they would get off the ward to smoke. On the day of our visit, we observed individuals continually asking staff about getting off the ward.

Care, treatment, support, and participation

Care records

Managers told us that some documentation had now been transferred to the electronic system TRAKCare, which was being rolled out across NHS Grampian. We

accessed individual electronic files on the day of the visit as well as paper files that were still in place.

The SCNs told us that the plan was for the wards to eventually have all documents transferred over to the electronic system and the recording being only on this system. We were told that all the ward-based staff and the MDT recorded all daily contact with individuals on the electronic system; the weekly MDT meetings were also on this system, along with risk assessments and risk management plans.

With nursing staff daily recordings now being completed on TRAKCare, we found the entries to be detailed, relevant, and meaningful, in that the recordings provided a good level of updates on progress about the care and treatment of the individual, which also incorporated their views. We saw evidence of one-to-one discussions happening between the nursing staff and the individual, as well as regular meetings that individuals had with their consultant psychiatrist.

The way in which these one-to-one meetings were recorded was inconsistent across the four wards, with some of these contacts not clearly identified in the care records as one-to-one meetings. However, most entries provided a good description of the individual's current mental state and their views about current treatment. As NHS Grampian have now moved to using an electronic system, we were able to see that all recordings were in the one place, which was a welcome improvement.

From reviewing an individual's file, the one-to-ones with nursing staff were not always clearly recorded and these appeared to be inconsistent across the four wards.

From reviewing the files, we were aware that the nursing staff continued to record their initial nursing assessments on the older style grey booklet that had previously been in place and that the plan would be for the assessment to be completed on TRAKCare in future.

We wanted to follow up on our last recommendation about risk assessment and risk management plans. We found that everyone had a completed and detailed rapid risk assessment in their paper file, and that these were reviewed regularly. We were told that nursing staff had begun to complete the risk assessments and risk management plans on TRAKCare and that these were being reviewed weekly, following the MDT meeting, or sooner if required.

While we saw some detailed and relevant risk assessment and risk management plans across the four wards, we did review some in each ward that were lacking in detail.

It was positive to hear that the staff had transitioned well over to the electronic system, and we look forward to seeing the continued changes and developments on our next visit.

Care plans
All care plans were in paper format and kept in a folder on the ward, which we found easy to navigate. We wanted to follow up on our last recommendation regarding care planning to see what progress had been made.

The service had devised new care planning documentation that was rolled out to all wards across the hospital in 2024. On our last visit, this new documentation had just been implemented and we saw some improvement in this area. We were also aware that a new audit tool had been implemented, and managers told us that they had identified areas where further improvement was required. We were told that there were audit processes in place that were carried out by the leadership team to improve aspects of the documentation.

We were advised that the two charge nurses in each of the wards carried out five care plan audits per month.

The quality of care planning in each of the four wards was variable. While we saw some evidence of detailed person-centred care plans, where regular reviews had taken place that evidenced individual participation, but this was not consistent in any of the wards.

We saw care plans where individuals had been involved from the development to the reviewing of their plans, along with evidence of one-to-one discussions about their plans; again, this was inconsistent across the four wards. We found some care plans that did not cover all of an individual's needs and for quite a few, there was no link between the recorded objectives and the outcome.

Many of the plans had a list of detailed actions, and while these were being met and actioned, these were often not linked to the care goal, therefore it was unclear if goals were being met and achieved. Many actions were written in a format that was task orientated, which lost the personalisation of the plan.

The SCNs told us that the care plans were reviewed weekly. All the care plans we saw were being reviewed regularly, however, reviews mostly provided limited information and often only recorded "remains relevant". We were aware that there were many individuals who had not been long admitted to the ward, therefore a number of the care plans had been newly devised and were not at the stage for review.

We found that participation in the process was variable, with some individuals either having signed their care plans, and/or had a copy of the document, or told us about

the process and of the goals they were working towards. Where a person did not wish to sign, this was also recorded. However, there were reasons being recorded that we would consider as unacceptable. For example, one individual's care plan recorded the reasons for the individual not being involved was because they were "sleeping" and another recorded "considered detrimental to mental state".

We met with some individuals who had not seen their care plan and others who knew exactly what they were working towards. This was the same across all the wards. While care plans may have been developed at the start of the individual's journey and perhaps the individual was not able to contribute at that time, we saw no evidence that these were revisited at various stages throughout the admission.

We heard from staff in the service that one of the identified areas for improvement was around relative and carer involvement in the care plan process. We are aware that there may be occasions where some individuals do not provide consent for their information to be shared with their relative and this can be difficult for staff, particularly where individuals' consent changes. On the visit we saw where some people had signed the consent form to share or recorded their wish not to share information. We would emphasise that this should be regularly reviewed and discussed with the individual throughout their admission.

The Commission had devised good practice guidance on carers, consent and confidentiality.

Recommendation 1:
Managers should ensure that all nursing care plans across the service are individualised, person-centred, and detail interventions which support individuals' movement towards their care goals. These should evidence individual and carer involvement, be regularly reviewed and the quality of the care plans should be audited.

The Commission has published a good practice guide on care plans[1]. 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.

Multidisciplinary team (MDT)
We were told that each ward held a weekly MDT meeting, and we were advised that everyone's care and treatment was discussed at this meeting. The representation at this meeting would include the consultant psychiatrist, nursing staff, OT, psychologist and social work/mental health officer where appropriate; we were also heard that the wards had good access to pharmacy who attended the meetings.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

We were advised that there were three vacant psychologist posts which had not yet been filled. We heard that since January, this had had an impact on service provision as there had not been any psychological groups delivered. This was disappointing to hear as on our last visit, we heard about the addition and the much-welcomed value of having psychology provision in the GAP service.

Since our last visit we were told that an inpatient clinical lead had been appointed. We also heard that there was more clinical time introduced across the wards which supported medical and nursing staff.

We met with the psychiatrists during the visit, and we heard how the links with community teams had improved since our last visit with the alignment of the teams. We were told that the inpatient doctor only provided care and treatment whilst a person was in hospital and that there was a different doctor who would oversee individuals care in the community. We also heard from staff and doctors that there were good links into the MDT from the community mental health teams, particularly Aberdeen City.

Each ward had a consultant psychiatrist along with a CESR (certificate of eligibility for specialist registration) doctor. The CESR fellowship programme is a route for doctors who do not have general medical council (GMC) registration, nor have they completed an approved UK training programme, but are working towards gaining entry on to the specialist register. The three-year programme is specifically designed to provide international psychiatrists with all the necessary support, including GMC approved sponsorship, relocation support and bespoke mentoring and experience to achieve the CESR portfolio in specific psychiatric specialities. We heard from the clinical leads about support and mentoring for these doctors in Grampian.

We were pleased to hear that the permanent consultant psychiatrist post had recently been filled in Fraser Ward.

We wanted to follow up on our last recommendation about the MDT process and documentation. As the MDT meetings were now completed on TRAKCare, we found that the recording of the meetings had improved. There was a record of who attended the meeting, which included if the individual was present at the meeting or met with the doctor after or before the meeting.

We found that the MDT meeting records were clear, concise and had a recorded plan of action. We saw some limited evidence of contact with a relative or where a meeting was requested, however, in general, relative/carer participation and involvement appeared minimal from the records viewed. The MDT format on TRAK care had good prompts for staff, such as escorted time off ward (TOW), treatment certificates, which all staff would benefit from utilising to ensure all individual rights regarding care and treatment were safeguarded.

We were told that as part of the MDT, each ward had a different approach to individual participation. We were told that individuals on Fraser and Fyvie Wards attended the meeting, but individuals on Huntly Ward and Dunnottar Ward tended to be seen out with the MDT meeting. We also heard from clinicians that where a person had been admitted from the islands there was consistent representation from Shetland professionals, however this was not the case from Orkney. We were aware that as part of the Dunnottar Ward improvement plan, the lead clinician who covered this ward had opened up four sessions per week to meet with individuals and/or relatives.

We were aware from speaking to individuals that they found the MDT process confusing, particularly if they had been boarded out to another ward. During our visit, we heard people continually making requests to staff to meet with the doctor. We found that people were moved when they were still in an acute phase of their illness and were often unhappy at being on a different ward.

For individuals where the purpose of a planned admission was to be brief, it was difficult to know how they were able to access the MDT provision. We were able to see the complexity of an individual's presentation from reviewing care records where there was often a dual diagnosis and experience of trauma. The lack of full MDT provision to care and treatment was apparent when reviewing these records, especially given inconsistent activity provision and access to psychological therapy. Where individuals required access to other allied health professionals (AHPs), such as dietetics and physiotherapy, we saw referrals to these services and a detailed description of their input and plan of action on TRAK care.

Doctors told us that there could often be high levels of clinical acuity on the wards and there were occasions where they have felt that a transfer to IPCU would be beneficial for the individual and others; however, access to this unit could be difficult. We heard last year that the IPCU pathway was in the process of being reviewed. We were pleased to hear that there was representation from GAP services on the review group. We will request an update from managers about the progress of this.

The wards continued to have input from OT, and we saw this on the day of the visit and from reviewing the care records. We found that some individuals had regular sessions with OT, and that these were activity-based, while others had assessments completed as part of discharge planning.

Use of mental health and incapacity legislation

On the day of the visit, 52 people were detained under the Mental Health Act. Dunnottar Ward had the lowest number of people detained compared to the other three wards.

All documentation relating to the Mental Health Act was held in individual paper files and easy to locate.

NHS Grampian had recently moved to the electronic prescribing system, HEPMA (hospital electronic prescribing and medicines administration) and the SCNs told us that the staff had managed this transition well.

We wanted to follow up on our recommendation from last year's visit about Mental Health Act treatment certificates, given the concerns we highlighted in our visit report. This was also a recommendation from our visit in 2023. NHS Grampian managers had submitted an action plan to the Commission as to how the previous recommendation was going to be met. Since our last visit we were told that there had been a further audit undertaken by the lead pharmacist and we received a copy of the outcome prior to this visit. The pharmacist had provided a good practice guide for staff following the audit in 2023 and this had been shared with staff across the services.

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. The majority of treatment certificates were easily located in a folder in the treatment room. However, we again had concerns about the consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act, as we found several individuals were receiving treatment out with the authority of the Mental Health Act.

We found that out of the 52 individuals that were detained, more than 30 people should have had a certificate in place to authorise their treatment. We found that 11 people across the four wards were being treated without the required legal authority in place. We fed this back on the day of the visit to the SCN's and pharmacy. We also had a follow up meeting with senior managers, including the inpatient clinical lead and informed NHS Grampian's medical director of our findings, as we were again concerned about the lack of improvement in this area and that individual rights continued not to be upheld.

We found that two individuals in Fraser Ward had been prescribed intramuscular (IM) medication, 'as required' medication on a T2 certificate. The Commission has concerns about IM 'as required' psychotropic medication being included on a T2 certificates, as any advance consent the individual has given is invalid if they have withdrawn their consent at a later time when the medication is given or if restraint is involved. It is our view that where IM medication has been prescribed 'as required' in hospital, it should be authorised on a T3 certificate. This was also the guidance that pharmacy had provided to staff. The consultant psychiatrist in Fraser Ward agreed to address this urgently.

Under Part 16 (section 243) of the Mental Health Act, urgent or emergency medical treatment may be given to someone who is detained in hospital and who does not consent or is incapable of consenting and this treatment is deemed to be in a person's 'best interests' and follows the requirements of the Act.

The T4 certificate is completed retrospectively and is used by the responsible medical officer (RMO) to notify the Commission of treatment given under section 243. The Act requires the RMO to notify the Commission within seven days, so treatments within seven days might be included on one T4 form. From discussion with nursing and medical staff we found that there was poor understanding regarding a T4 certificate. We met up with the lead pharmacist on the day of the visit and provided direct feedback regarding the issues that were found. They also agreed to update and redistribute the guidance.

We found inconsistent recording of T2/T3 certificates in the HEPMA system across all four wards, which meant that the system would not readily flag up to the prescriber/administrator what certificate was in place.

Due to this recommendation being made previously and not being met from our last two visits, along with the concerns we found again on this visit, it would appear that the previous action plan to address this was not robust enough. In addition, we have identified a clear MDT training issue across the GAP service, therefore this recommendation will be repeated.

Recommendation 2:
Managers must ensure that all psychotropic medication is legally authorised and regular audit undertaken to ensure significant improvement in this area is achieved and maintained. Consideration should be given to inhouse training to increase and improve staff knowledge in this area.

We will continue to follow up on individual cases across the four wards to ensure that individuals rights are being upheld with regards to their care and treatment.

Where individuals were subject to high dose psychotropic monitoring, we found high dose monitoring protocols were in place.

For individuals who had covert medication in place, the documentation was in order, as well as the pathway where covert medication was considered appropriate.

For those people that had a proxy appointed under the AWI Act we found a copy of the legal order in their file.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found that where a section 47 certificate was in place, there was a treatment plan attached.

We wanted to find out about our last recommendation requiring a training needs analysis regarding AWI Act Legislation. In Dunnottar and Fraser Wards, we still found entries in nursing notes where it had been recorded that an 'AWI was in place', and did not provide any detail on the exact legal section. Managers told us that they had not managed to action the training needs analysis yet and that this was still part of their improvement plan. As there has been no development in this area, we will repeat last year's recommendation and request an update in due course.

Recommendation 3:
Managers should carry out a training needs analysis and identify staff training gaps around AWI Act legislation to enhance the workforce's knowledge base.

The Commission has worked jointly with NHS Education for Scotland (NES) to develop training in relation to the Adults with Incapacity Act and an eLearning module has recently been launched on TURAS. This can be accessed by anyone in the workforce and has been developed for those working with people aged 16+ years who may be considered to lack capacity to make some or all decisions.

Rights and restrictions

The door to all the wards were locked, and NHS Grampian had a locked door policy in place.

From meeting with individuals, they were able to tell us about access to and from the ward, particularly where there were not detained. It was positive to hear that most individuals who we met with and who were detained had received letters about this and were able to tell us about their rights. The ward had good access to advocacy and on the day of the visits, advocacy held community ward meetings in Dunnottar and Fraser Wards. Advocacy told us that attendance at these meetings could vary and although individuals were told that information was confidential, we were reassured to hear that collective issues were shared with senior managers to address any specific issues. We heard of some issues that were discussed and were satisfied that these would be raised by advocacy with senior managers.

We viewed the white boards in the duty rooms across all four wards and noted that individuals time out of the ward (TOW) was restricted at times, regardless of whether the person was detained or informal. While we saw that nursing staff were capturing the TOW status in the care planning and risk assessments documentation, individuals' views were often not recorded, particularly when they were informal. We suggested to managers that it was important to capture an individual's views on

their TOW status, especially for those who were not detained under the Mental Health Act.

Huntly Ward had a patients' rights pathway displayed on their wall, which was informative and provided guidance.

Individuals told us about the support from advocacy and their attendance at the Mental Health Tribunals Scotland (MHTS) tribunals. We heard from a few people that they were disappointed when scheduled in-person tribunals had been changed to teleconference ones via telephone. We asked the service if there had been issues with the scheduling of mental health tribunals and were told that there had perhaps been an increase in the number of appeals of short-term detentions, and due to short notice of those, the individual had been informed by MHTS that it was too difficult to schedule an in-person tribunal.

Sections 281 to 286 of the Mental Health Act provide 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 the relevant paperwork to be in place, along with reasoned opinion. We are aware that Grampian has devised a reasoned opinion template and saw this being used across the wards. We discussed one individual's case on Dunnottar Ward where it was recorded on the information board that the person was subject to specified person legislation. On further discussion, the individual was no longer a specified person and we requested that the board be updated promptly.

We wanted to find out about our last recommendation about the training needs analysis for staff around specified person legislation. We were told there had been a delay and that the analysis had not yet been undertaken. We were also told that there had been no specific audits carried out. As this recommendation had not been met, we have repeated it.

Recommendation 4:
Managers must undertake a training needs analysis to identify gaps in and enhance all staff's understanding of specified person legislation.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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. While we saw a few advance statements, we felt that there was no specific promotion of these on, or throughout an individual's admission.

While we recognise that individuals may be not be able to make one at the time of admission, we felt there was no discussion or follow up either in one-to-one sessions, during care plans reviews or on discharge. We had a few people ask us about these on our visit and we had further discussions with managers about the promotion of these. This would also be an area where advocacy could support individuals, if appropriate to make one of promote them in the community ward meetings.

Recommendation 5:
Managers must ensure that individuals are informed and supported to make an advance statement where they chose to and where they do not wish to make one that this is recorded in the care records. This should be reviewed throughout the admission and prior to discharge.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

On our last visit we saw that there was a good level of activity provision in place and people told us that felt they benefitted from the offer of therapeutic activity in place. However, on this visit most people told us that there was not enough to do.

People told us about the benefit they felt from attending the psychology groups, but there had been no psychology groups running since January due to staff vacancies.

We heard from some individuals that they spent most of the time in their bed or room as there were no activities to do. Without access to therapeutic activities, some individuals told us that they had to rely solely on medication to help them get better. On review of individuals' care records, we also found a lack of engagement in meaningful activity particularly across Dunnottar, Fyvie and Huntly Wards.

On our visit in 2023, we heard about the recruitment of three activity nurses to support the activities across all wards and to aid in an individual's care and recovery. On last year's visit we saw the positive promotion of and participation in activities. However, on this visit, we found a lack of activities and across the wards, with the exception of Fraser Ward, where there was still an activity nurse in place.

Since our last visit, managers told us that there was only one post filled and the other two were vacant. We were provided with an update with regards to the activity nurse posts and we heard that there was a review of the roles and responsibilities. We also heard that the plan was to recruit to these posts.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Individuals across the four wards told us about the input from the physiotherapist and how they enjoyed going to the gym or walking groups.

It was disappointing to hear of the many changes in relation to activity provision particularly following last year's visit, where the level of therapeutic activity on offer, clearly enhanced people's recovery.

Recommendation 6:
Managers should consider measures to enhance the level of activity provision across all four wards, especially in the interim period where there are vacancies in psychology and activity nurse provision.

The physical environment

The four wards compromised of single en-suite rooms and dormitories with shared showering facilities. We were told that the single bedrooms were largely for individuals who were acutely unwell, who required continuous intervention or for a variety of other reasons, such as physical health care needs.

While some individuals told us that they found it difficult to share a dormitory due to a lack of privacy and noise, we spoke to quite a few who told us that they preferred the shared dormitory and enjoyed the company of others. We spoke to a few people who had their own single rooms but told us that they still found the noise levels on the ward distressing.

Some individuals on Dunnottar Ward told us that people were allowed to play loud music in the night which they found difficult and which had an impact on their sleep.

We heard from some individuals that they found the lack of privacy across the wards difficult, especially where they were not able to leave the ward and had visitors. Each ward had one quiet room; however, there were available rooms off the ward where some individuals could meet with their visitors and professionals.

These wards had previously undergone renovations, including ligature reduction works. The environments were bright, clean and each ward had a dining area, and lounge area with a TV.

None of the wards had access to a garden and we heard from individuals of the difficulty in getting fresh air, where they were restricted to the ward environment.

We heard from many individuals across all four wards that it was difficult to get out to smoke. We also heard this from the staff team, where individuals constantly asked throughout the day to leave the ward to smoke.

We wanted to follow up on our recommendation last year about the maintenance of the wards as we heard that items could take a while to get fixed. Managers told us about some doors in the ward which required repair, and they continued to follow

this up. We were told that these types of repairs were escalated quickly however, the issues with the doors lay with the contractors, which often took longer to have repaired.

Some individuals in Dunnottar Ward told us that the checks by nursing staff during the night could be disturbing, as they used a torch to look in the rooms and dormitories which could be daunting and disruptive. Whilst we were sympathetic to this, individuals understood the reasoning and requirement for these checks.

Individuals feedback in relation to the environment varied across the four wards. Some people told us that they felt safe, whereas some individuals told us they often felt scared and unsafe, depending on who was in the ward. This feedback was consistent across all four wards.

Managers told us that the buzzer system was not working in Huntly Ward, but this was being attended to. We subsequently heard that it was repaired shortly after our visit.

Summary of recommendations

Recommendation 1:
Managers should ensure that all nursing care plans across the service are individualised, person-centred, and detail interventions which support individuals' movement towards their care goals. These should evidence individual and carer involvement, be regularly reviewed and the quality of the care plans should be audited.

Recommendation 2:
Managers must ensure that all psychotropic medication is legally authorised and regular audit undertaken to ensure significant improvement in this area is achieved and maintained. Consideration should be given to inhouse training to increase and improve staff knowledge in this area.

Recommendation 3:
Managers should carry out a training needs analysis and identify staff training gaps around AWI Act legislation to better enhance the workforce's knowledge base.

Recommendation 4:
Managers must undertake a training needs analysis to identify gaps in and enhance all staff's understanding of specified person legislation.

Recommendation 5:
Managers must ensure that individuals are informed and supported to make an advance statement where they chose to and where they do not wish to make one that this is recorded in the care records. This should be reviewed throughout the admission and prior to discharge.

Recommendation 6:
Managers should consider measures to enhance the level of activity provision across all four wards, especially in the interim period where there are vacancies in psychology and activity nurse provision.

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 an individual's care, treatment, and support are 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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