Mental Welfare Commission for Scotland

Report on unannounced visit to:

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

Date of visit: 23 August 2023

Where we visited

Corgarff Ward is a 16-bedded, mixed-sex, slow stream rehabilitation ward that is based at the main Royal Cornhill Hospital.

On the day of this visit we wanted to follow up on the previous recommendations that regular review meetings took place, that reasoned opinions and reviews took place where there were specified persons, and that there were individualised activity planners. We also wanted to also speak with individuals on the ward, relatives, and staff. We also wanted to find out how the service was continuing to make progress with the recommendations from our themed visit report, *Scotland's mental health rehabilitation wards,* which was published in January 2020.

Who we met with

When we plan an announced visit, prior notice is given to patients and relatives of our intention to visit. This visit was unannounced, therefore we were unsure if we would have the opportunity to speak with relatives as well as individuals on the ward on the day. However, we managed to speak with four relatives, and we spoke with and reviewed the files of seven patients.

We spoke with the senior charge nurse (SCN), ward staff, and the consultant psychiatrist.

Commission visitors

Tracey Ferguson, social work officer

Alyson Paterson, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

On the day of the visit there were 16 patients in the ward. Managers told us that 12 of the 16 beds had been identified for individuals who required rehabilitation, three beds were for contingency and one bed for the community rehabilitation team to access. We wanted to find out about any impact of patients boarding from other wards, as on our previous visit, managers told us that there was significant pressure during the Covid-19 pandemic to admit patients from the adult acute wards; resulting in the ward's loss of identify around the main purpose of rehabilitation.

On this visit there were five individuals boarding from the acute wards and managers told us about the additional pressure that this brought, along with the challenges related to nursing staff. We were told that most of the nursing tasks were being diverted to those acute patients, creating an impact on the delivery of care and support to those who were there for rehabilitation purposes.

Managers told us that there continued to be a daily managers huddle that specifically reviewed staffing across the services, along with discharges and bed provision. We were also told that this meeting included any discussions about patient transfers to specific wards ensuring that individuals' needs were considered and that there was agreement between senior charge nurses of each ward.

Care, treatment, support, and participation

Patients in a rehabilitation service are likely to have complex mental health needs, along with comorbid conditions; they can often spend many months, or years, in hospital. During our visit, we found that most individuals had had previous and multiple admissions to psychiatric hospitals, over several years, often resulting in lengthy stays in hospital. Most of those on the ward had been in an acute ward and had transferred to Corgarff Ward following a multidisciplinary decision that they would benefit from rehabilitation; this was not the case for the five individuals who were boarding.

Throughout the day of our visit, we chatted to those in the ward and introduced ourselves. Feedback from individuals about staffing was positive. Some people told us that the staff listened to them and that they knew who to approach if they needed support. Others told us that they felt involved in their care and treatment, and in decision-making in relation to their recovery and future. A few individuals told us that they were bored as there was not enough to do, whilst others told us about their weekly programme of activities. Most people knew who their responsible medical officer (RMO) was and told us how they met with them regularly, and this was the case for some of the individuals who were boarding, but not all.

One individual told us about having no access to finances, and we spoke with SCN about this on the day of the visit.

The feedback from relatives about the staff on the ward was positive and complimentary, with some telling us, "staff do an excellent job", "best I have ever seen" and that they were "happy with progress". One relative commented about the improvement in their relative's mental and physical health since being on the ward. All relatives told us that the communication was good and that they felt involved and attended review meetings. One relative told us about the

flexibility of the meetings, as the meeting was online via Microsoft Teams; this had enabled them to attend more meetings than previously. We heard from one relative that some activities were not as person-centred as they would have liked, and they felt that the activities could have been more individualised to their relative's needs.

Care planning and documentation

Of the individual files we reviewed, we saw detailed holistic nursing assessments that were completed on admission, and updated where necessary, depending on length of admission. These included risk assessment and risk management plans that were also reviewed and updated where necessary.

In relation to care planning, we found reasonable detail in the plans, focussing on the needs and strengths of the individual. However, this was variable and did not always address all the individual's needs. The plans also lacked definition and detail around rehabilitation goals, and this is what we found on last year's visit. Due to this lack of detail, it was difficult to see what progress had been made with regards to the individual's rehabilitation journey. The care plans had been developed from generic documents used throughout NHS Grampian mental health services and therefore did not lend themselves to focus on rehabilitation. We had a further discussion about the documentation with the SCN and clinical nurse manager on the day, and we were advised that there was a group across NHS Grampian tasked to make improvements around care planning and documentation. We will link in with managers about the outcome of this group. We asked about audit processes that were put in place for the documentation. The SCN told us that monthly audits were carried out.

We had a discussion with managers about involvement with the patients, as some of those that we spoke with were able to tell us about their care and treatment. We saw that some care plans had written that the patient was unable to sign, and we saw a few where it was recorded that the patient refused to sign. We suggested to the SCN that it would be good practice to discuss and revisit care plans with individual patients at their review meetings and record where this has occurred.

We found evidence of physical health care monitoring being provided throughout the patients' journey and were told that the GP visits the ward weekly to discuss physical healthcare, which was recorded in each patients' files.

Recommendation 1:
Managers should review the current care plan audit process to ensure that the care plans reflect and detail interventions which support patients towards their care goals, evidence patient and carer involvement, and contain regular reviews and summative evaluations.

Multidisciplinary team (MDT)

When patients are treated in a rehabilitation service, we would expect that they have access to a full range of professionals that are involved as part of a multidisciplinary team (MDT), and who provide the requisite skill mix to deliver care that is focussed on rehabilitation.

This ward had a rehabilitation consultant psychiatrist who also covered the community rehabilitation team, which ensured continuity for patients following discharge. One of the

individual patients that we spoke with commented on this and told us that it was good to have the same doctor in hospital and in community.

We were told that MDT meetings took place weekly. With individuals at different stages of their rehabilitation journey, we were told that not all patients were discussed weekly, as some may be discussed fortnightly. Attendance at the meetings mainly consisted of the consultant psychiatrist, nursing staff, occupational therapy (OT) staff, clinical psychology, and pharmacy. We were pleased to see the range of input from the MDT in the planning and delivery of care. Where some individual patients required input from other specialisms, this had been identified and discussed at the MDT and those services accessed as part of an individual's care and treatment.

In the MDT record, we saw that there was an entry of who attended, along with a nursing entry that provided the update for the meeting. The MDT minutes were variable in the level of detail and for some of that were boarding, we were told that the reviews and input into their care and treatment by the consultant psychiatrist was inconsistent. The SCN and nursing staff told us that a significant amount of their time was spent in supporting discharges for the patients who were boarding in Corgarff Ward.

We were told a boarding protocol was in place and that the consultant psychiatrist from the ward that the patient was boarding from, had a responsibility to review each patients' care and treatment.

Recommendation 2:
Managers must review the current boarding protocol that is in place to ensure that all patients receive equitable and consistent review of their care and treatment by the consultant psychiatrist and any other multidisciplinary professionals from the ward that the patient is boarding from.

We wanted to follow up on our previous recommendation with regards to the ward's review processes. We were pleased to see that there were regular reviews built into the individual's rehabilitation journey at three and six month intervals; we saw minutes of meetings where these were available. There was one patient who had not had a review carried out in the three-month timescale. We discussed this with the SCN and were told that a review is scheduled.

We asked if the service had introduced any specific models for the standardised review meeting after our discussion at last year's visit. Due to the specific number of patients who had complex mental and physical health care needs, we felt that it would be beneficial for the ward to consider an approach such as the Care Programme Approach (CPA) that provides a robust framework for managing patient care or an Integrated care Pathway (ICP). We were told that the service had not introduced anything yet, but there had been discussions in the wider NHS Grampian care planning group and this was an area that they were continuing to consider. However, we were advised the service wanted to address the care planning issue initially.

As part of the patient pathway to the community, we were told that some individuals may be referred to the community rehabilitation accommodation at Polmuir Road and others may move onto other permanent or interim placements to continue their rehabilitation. We were

told that the community rehabilitation team would follow these patients up in the community, and link in with the ward prior to discharge, which we felt was positive and provided continuity.

We asked the SCN about patients who were recorded as delayed discharge. We were told that there were six individuals that were recorded as delayed discharged. However, on reviewing files we found that there were discrepancies in how this was being recorded. We found some entries recorded 'delayed discharge' whilst other entries recorded 'delayed transfer of care' (DTOC). All six patients had these terms recorded interchangeably in their notes. Further discussions around these lists provided no clarity, which was consistent with what we found on other recent local visits to NHS Grampian. We were aware that NHS Grampian were operating two lists. We will continue to have discussions with senior managers regarding this, in an effort to understand how delayed discharges are recorded accurately and then reported to the Scottish Government.

Use of mental health and incapacity legislation

Eight individuals were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) and of the files we reviewed, we found that the Mental Health Act detention paperwork was all in order.

Part 16 (sections 235-248) 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place, apart from one and we discussed this further with the consultant psychiatrist on the day of the visit. There had been a treatment certificate, but it was not located in the ward file.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this in their file.

For any patients who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), we saw a copy of the legal order in their file.

There were some entries in files and the staff board that recorded the patient was subject to 'AWI', rather than the specific legal order. We also found this to be an issue on last year's visit, so we brought this to the SCN's attention, again highlighting that this lack of clarity regarding the measures authorised under AWI Act legislation, could lead to confusion.

Following the Commission's recent Authority to Discharge project, the Scottish Government provided funding to develop an Adults with Incapacity framework for staff and this continues to be progressed jointly by the Commission and NHS Education for Scotland (NES). We will continue to keep the Health and Social Care Partnerships and NHS Grampian updated of this development, as this will enhance staff knowledge when working and supporting people subject to AWI legislation.

Our authority to discharge report can be found via the link below:

AuthorityToDischarge-Report_May2021.pdf

Where patients are assessed as lacking capacity to consent to treatment, and treatment must be provided under part 5 of the AWI Act, s47 certificates authorising treatment should be completed. This certificate is required by law and provides evidence that treatment complies with the principles of the Act. We found two patients where there had been a s47 certificate and the treatment plan had been completed. We also advised that all treatment certificates should be kept together, to enable nurses to be aware when administering treatment that there is sufficient authority in place.

https://www.mwcscot.org.uk/sites/default/files/2021-10/Scope-Limitations-S47_advice2021.pdf

Rights and restrictions

The door to the ward was not locked, and patients we spoke with were aware of this. We noted that there was a board in the nurses' office that recorded the permitted time out of the ward for all patients. We had a discussion with the SCN about this, as those individuals who were not detained under the Mental Health Act should not be restricted from leaving the ward unless they agreed, and it is then care planned for and recorded in their notes.

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

S281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on patients who are detained in hospital. Where an individual is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. There were no patients on this visit who had been made specified.

The ward had good links with the local advocacy service that was based in the Royal Cornhill Hospital. We were able to see from reviewing files, where individual patients had support from an advocate at meetings and tribunals.

When we reviewed files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We found recordings in patients' notes, where they did/did not have an advanced statement in place. Where it was recorded that the patient did not have one in place, there appeared to be no follow up discussion after the admission process had been completed regarding an advance statement. We also found this to be the case on our last visit. One of the recommendations from the Commission's themed rehabilitation report was for NHS Boards to develop plans to promote the knowledge and use of advance statements in rehabilitation services. We had a further discussion with the SCN about this and felt it would be beneficial for the service to build in these discussions into individuals' rehabilitation journey, and for work to continue on this alongside advocacy services, who could work with the service to help promote patients' rights.

Recommendation 3:
Managers must ensure that patients are informed and supported to make an advance statement where they choose to, and where they do not wish to make one that this is recorded in the patients' notes. This should be visited throughout the patient's rehabilitation journey.

Activity and occupation

Many of the patients in the ward have spent long periods in hospital, which can significantly affect the skills and abilities needed to live back in the community. To address this, we expect a specialist inpatient rehabilitation service to have individualised activities to promote recovery, demonstrated by activity planners/timetables to help patients gain, or regain the skills and confidence needed to progress their recovery.

We were told that the ward had dedicated input from OT to provide therapeutic based activities on a one-to-one basis and in groups. The ward also had an activity nurse who is shared with another ward, and we saw those activities written on the board displayed in the ward corridor.

Some patients were able to tell us about the range of activities that they were participating in and the groups they attended; others told us that there was not enough to do.

We found detailed OT assessments in individual patients' files, along with detailed recordings from the OT regarding activities and interventions. Those that we spoke with, and staff told us about the groups that were on offer, such as breakfast, lunch, art, and community groups. We saw that individuals had a copy of activity planners in their files however, we found that the planners were much the same for most patients and lacked personalisation.

The ward had a new rehabilitation kitchen completed last year and we heard from staff and patients about the benefits of having this facility on the ward that supported patients in regaining their skills around this activity of daily living.

The physical environment

The layout of the ward consists of single rooms and shared dormitories, along with a large dining/sitting area that led out to the enclosed garden area. Some patients told us that they liked sharing a dormitory, as it provided them with company, whilst others told us that it could be noisy.

There was a pool table in the main sitting lounge area, as well as a television; there was a quieter lounge that patients were also able to enjoy. The garden was being used by people on the day of our visit, and we were told of the work that the patients had done with OT in growing vegetables. We heard how patients had been heavily involved in this development and were benefitting from the home-grown vegetables as part of their meals. We saw positive reviews by the OT in patients' records that noted an educational element to the skills sessions.

There were ample shower/bathroom facilities and amenities for patients to do their own washing, although the laundry room is off ward and shared with another ward.

Summary of recommendations

Recommendation 1:
Managers should review the current care plan audit process to ensure that the care plans reflect and detail interventions which support patients towards their care goals, evidence patient and carer involvement, and contain regular reviews and summative evaluations.

Recommendation 2:
Managers must review the current boarding protocol that is in place to ensure that all patients receive equitable and consistent review of their care and treatment by the consultant psychiatrist and any other multidisciplinary professionals from the ward that the patient is boarding from.

Recommendation 3:
Managers must ensure that patients 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 patients notes. This should be visited throughout the patient's rehabilitation journey.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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.

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