Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 3 December 2024

Where we visited

Corgarff Ward is a mixed-sex, 16-bedded unit that provides slow stream rehabilitation for adults. The ward is based in Royal Cornhill Hospital and on the day of the visit there were 14 people in the ward; one individual was boarding from the adult acute ward.

We last visited this service in August 2023 on an unannounced visit and made recommendations with regards to advance statements, the boarding protocol and care planning.

On the day of this visit, we wanted to follow up on the previous recommendations and get an update from managers about how the ward was meeting the needs of individuals who were boarding to this ward.

Who we met with

We met with five individuals and reviewed their care notes, and we reviewed a further three individual care notes. We also spoke with two relatives.

We spoke with the service manager, the senior charge nurse (SCN), ward-based staff, the lead nurse and consultant psychiatrist.

Commission visitors

Tracey Ferguson, social work officer

Kathleen Liddell, social work officer

Susan Tait, nursing officer

What people told us and what we found

Individuals 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.

On this 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. There were a few individuals who were in the ward on our last visit and had remained there. We requested an update regarding their rehabilitation progress.

The SCN told us about some of the discharges that had taken place since our last visit, and we heard about the plans for others. We were aware of one individual where a clinical decision regarding rehabilitation was no longer appropriate, and the consultant psychiatrist provided us with an update. We found on this visit that individuals were at different stages of their rehabilitation journey, with some individuals progressing more swiftly than others; for some, the priority continued to be the stabilisation of their complex physical and mental health.

The SCN told us that since our last visit, the ward had continued to receive boarders from other wards, and this was due to the unavailability of beds in the individuals' catchment area. On last year's visit we heard about the impact of individuals boarding from other wards, and of the additional pressure that this brought, along with the challenges related to the nursing staff on this ward.

Although we continued to hear about the impact of this, we also heard about the improvements in practice with the wards forming better relationships and the proactive efforts of the leadership team in Corgarff Ward to ensure that individuals care, and treatment continued to be reviewed by their own ward consultant, although we were told that the consultant reviews were inconsistent.

We requested an update from senior managers about the boarding protocol and were told that this had been reviewed and updated and was due to be presented to the clinical governance group for sign off and dissemination. We will link in with senior managers and request a copy once this has been approved.

Managers told us that there continued to be a daily managers huddle that reviewed staffing across the services, along with any discharges and bed provision. We were also told that this meeting included any discussions about individual transfers to specific wards to ensure these were appropriate and that the needs of individuals were fully considered. The SCN also told us that where an individual's needs could no longer be met in the ward or the risk had increased, there were scheduled discussions about transfer back to their own ward.

The SCN and consultant psychiatrist provided us with an example where an individual from the adult acute service had been transferred to the ward, but upon reviewing their needs, a decision was made that the individual would not benefit from rehabilitation. Senior managers also told us that there was work ongoing across the service to promote the use of the rehabilitation service.

Throughout the day of our visit, we chatted to those in the ward and introduced ourselves. Feedback from individuals about staff was positive. We heard from those that we spoke with that they found that staff listened to them, whilst others told us that they felt involved in the decision-making about their care and treatment, in relation to their recovery and future planning. We discussed an aspect of an individual's care and treatment with the SCN and consultant psychiatrist and were reassured that all was being done to address the matter.

Some individuals were able to tell us about their involvement in their care plans, about their rehabilitation goals and about their weekly plan of activities. Most people knew who their responsible medical officer (RMO) was and told us that they met with them regularly to discuss their care and treatment.

Some individuals told us that they did not mind sharing a dormitory with others. However, we heard from one individual that they preferred not to share due to the lack of privacy. A few individuals told us that they felt safe in the ward and were able to tell us about their rights. One individual told us that they felt bored in the ward but was able to tell us about the range of activities on offer. Most individuals told us that they felt involved in decision-making, however, this was not the view from one individual we met with.

The feedback from relatives about the staff on the ward was positive, with one telling us that, "the staff are great, they always ask how I am" and "I feel involved and the communication is good".

One relative commented about their loved one feeling safe on the ward and that they were happy they were being looked after and that the admission was helping to stabilise their mental illness.

We heard from one relative that they did not feel as involved; we discussed this further with the SCN on the day of the visit, who agreed to follow this up.

Care, treatment, support, and participation

Care plans

We wanted to follow up on our previous recommendation about care planning. We had been made aware on our last visit that there was a working group across the Royal Cornhill site that looked to improve care planning documentation and

processes; we heard on our last visit that the documentation was just being rolled out to some wards.

On this visit it was positive to see that all care plans had been changed to the new documentation. We found that most care plans in place were detailed, person-centred and identified goals. However, the standard was variable across the records we reviewed, and some care plans did not always address all of the individual's needs. On last year's visit we found that the plans lacked definition around rehabilitation goals and again on this visit, the specific rehabilitation care plan lacked detail and definition. Due to this lack of detail, it was difficult to see what progress had been made with regards to the individual's rehabilitation journey. Information in the section 'plan of intervention' was of mixed quality; some lacked in detail and did not provide comprehensive information on the interventions that were required to support the care need. For example, we saw where an intervention was recorded "to build a therapeutic relationship", but there was no information as to how this was to be achieved. Some care plans goals were SMART (specific, measurable, attainable, relevant and time-bound).

All the care plans we saw were being reviewed regularly and whilst some of them had detailed reviews, we were disappointed to find that most of the reviews simply recorded "remains relevant". We provided examples to the SCN on the day of our visit. We viewed the care plans that the occupational therapist (OT) had devised, which provided detailed information as to the interventions required to meet the goals. We were pleased to see that OT care planning clearly set out the therapy goals and required interventions.

Recommendation 1:
Managers must ensure that care plan reviews are detailed and meaningful and that these reviews are consistent across the ward.

We found that participation in the process of care planning had improved, and some individuals had either signed their care plans, 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 them, this was also recorded.

We were made aware from other visits that a new audit tool had been devised as part of the improvements and there had been an audit carried out across the other wards in the hospital to see how the tool was working. We will continue to request and update from the lead nurse regarding the progress of improvements.

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.

Care records

We were aware from other visits across the Royal Cornhill site that some documentation had recently 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 some paper files that were still in place. The SCN told us that the plan was for the ward to eventually have all recording and documents transferred over to the electronic system. We were told that all the ward-based staff and multidisciplinary team (MDT), record their daily contact with individuals on this system and that the weekly multidisciplinary meetings were also recorded on TRAKCare. Corgarff also recorded the risk assessment and risk management plans on the electronic system. We are aware of plans to roll this out to all mental health and learning disability wards across NHS Grampian, which will allow records to become integrated.

We found most of the daily continuation note entries to be detailed, relevant, and meaningful in that the recordings provided a good level of updates on progress with the care and treatment of the individual and with incorporated their views. However, for some individuals who were not engaging in their rehabilitation planner, we found that these entries were less descriptive and at times the daily entries recorded phrases such as “low profile”, “evident on the ward” and “remained in bed space all day”. We discussed this further with the SCN as it was unclear what efforts were being made to actively encourage the individual to progress with their rehabilitation goals. From speaking to the staff, we heard about the difficulties and complexities of the situation however, this did not always come across in the records.

We saw some evidence of one-to-one meetings happening between the nursing staff and the individual. We reviewed some records where these discussions were not always being recorded as one-to-one meetings, so we brought this to the attention of the SCN. We did find recordings of when an individual had been offered a one-to-one meeting but had declined. We saw that there were regular meetings occurring with individuals and their RMO, and from reviewing the records, the entries by the RMO provided a detailed account of the individual’s current mental state and recorded their views on aspects of their care and treatment.

As all multidisciplinary staff were now using TRAKCare, we felt this was an area where there had been improvement, as records and updates about individuals care

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

were now being recorded in one place, as opposed to having separate recording systems.

In terms of risk assessments and risk management plans, we found a rapid risk assessment in each of the care records and risk assessment and risk management plans on the system. We were told that this transition was relatively new and whilst the risk assessments were mainly comprehensive, the risk management plans generally lacked detail about how the risks were being managed.

Recommendation 2:
Managers must ensure that risk management plans provide detail as to how risks are to be managed for individuals and ensure that these are regularly reviewed as part of the MDT meetings and rehabilitation review meetings.

Multidisciplinary team (MDT)
When individuals are treated in a rehabilitation service, we would expect them to have access to a full range of professionals involved as part of a MDT, to provide the requisite skill mix to deliver care that is focussed on rehabilitation; this was available to those in Corgarff.

The rehabilitation consultant psychiatrist attached to the ward also covered the community rehabilitation team, which enabled continuity for individuals following discharge. The MDT meetings took place on a weekly basis and the attendance at the meetings mainly consisted of the consultant psychiatrist, nursing staff, OT staff, clinical psychology, and pharmacy.

We were pleased to see this range of MDT members involved in the planning and delivery of care. We discussed one case where we felt that the individual and staff would benefit from psychology input with regards to a psychological formulation; we thought that this would support the staff to manage the individuals stress/distress behaviours, particularly around the use of non-pharmacological interventions.

We found evidence of physical health care monitoring being provided throughout each individual's journey and were told that the GP visited the ward weekly to discuss physical healthcare. This was recorded in the care records we reviewed.

Where some individuals required input from other specialities, such as dietetics and physiotherapy, this had been identified and discussed at the MDT and those services accessed as part of an individual's care and treatment.

The weekly MDT meeting was recorded on TRAKCare, and the records that we reviewed provided a detailed overview and update of the individuals' care and treatment. Details of who was present at the meeting, along with outcomes, actions and individual requests were recorded. We found the new electronic recording

format to be robust and it covered all necessary aspects, including ongoing monitoring of physical healthcare.

From our review of the care records, we also saw evidence of the individual's views being sought and recorded. The new format enabled prompts to review treatment. Staff told us that they were getting used to this new format and thought that there had been an improvement in a short space of time. The leadership team told us that there may be some areas in the electronic system which require further improvement, however we were pleased to hear that staff had adapted well.

We were told that individuals did not always attend the weekly MDT meeting and although individuals could make requests for this meeting, and nursing staff met with the individual to ask if they had any requests, we found that these requests were not always being recorded.

We wanted to follow up last year's recommendation regarding individuals who were boarded to this ward to find out how those individuals accessed their MDT. The SCN told us that for those people, they were still able to access the MDT, such as OT and psychology, in Corgarff Ward. However, we were told that the review of individuals by their doctor was variable and inconsistent, depending on the ward that they were transferred from. The SCN and charge nurse (CN) told us that they attended the wards MDT meeting to ensure the individuals care was being reviewed, that key clinical discussions and updates were taking place. We were told that this was working well although was often time consuming.

As the revised boarding protocol was being delivered to the clinical governance group, managers of NHS Grampian will need to have a process to monitor how the protocol is being implemented to ensure all individuals care and treatment is being reviewed consistently, regardless of what ward they have been transferred to.

We were told that rehabilitation reviews continued to be set at regular intervals throughout the individual's journey, initially at three and then usually at six-month intervals thereafter, or sooner if required. Review meetings were attended by all the MDT, including the allocated social worker, the individual and their relative/carer where possible.

Although the review records provided a good level of detail, we felt that there were parts of an individual's care and support that were not discussed in this meeting, and it was difficult to see the progress towards the goals that had been made or still needed to be achieved. We found that the review format and documentation did not provide a holistic update, which was similar to what we found on our last two visits to the ward. From speaking with staff, we found that the unit had a strong focus on both person-centred and multi-agency approaches to care and treatment although there was a lack of evidence of this in the documentation.

We found that many MDT professionals recorded lots of information in the individual's file but a joined-up approach to individuals' rehabilitation was missing. We felt that a MDT framework, such as care programming approach (CPA) or integrated care pathways (ICP) could be useful in remedying this. CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment through the involvement of a range of different professions and by keeping the individual and their recovery at the centre. ICPs outline the care an individual should receive from a multidisciplinary perspective, giving a clear timeframe for that care in order to aid progression and recovery.

Recommendation 3:
Managers should consider implementing a standardised multidisciplinary framework for reviewing individuals' care and treatment in the rehabilitation setting, such as CPA or ICP.

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.

One individual we spoke with was positive about the move to Polmuir Road to continue with their rehabilitation in the community setting. We were told that the community rehabilitation team would continue to follow individuals care up in the community, and link in with the ward prior to discharge, which we felt was positive as this provided continuity. We asked the SCN about individuals who were recorded as delayed discharge and were told that there was one person whose discharge from hospital had been delayed. We received an update regarding their discharge planning and were concerned to hear that there had been no progress since our visit last year. We will follow this case up with senior managers.

Use of mental health and incapacity legislation

On the day of the visit 10 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We found that the Mental Health Act detention paperwork was all in order.

NHS Grampian had recently moved to the electronic prescribing system, HEPMA (hospital electronic prescribing and medicines administration) and the SCN told us that the staff had managed this transition well. All treatment certificates were kept in a file and were easily accessible.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and

certificates authorising treatment (T3) under the Mental Health Act were in place where required and whilst they corresponded with the medication being prescribed, we found some issues with the T2 certificates. We found that the prescribed medication had not been written on the consent form that the individual had signed. Our view is that the consent form should clearly record the prescribed medication, to demonstrate consent to that prescribed treatment.

We discussed this with the consultant psychiatrist and SCN on the day of the visit. We also discussed matters in relation to T4 certificates and we advised the consultant psychiatrist that a T4 certificate was a retrospective notification to the Commission which should be submitted within seven days of the administration of emergency medication given under section 243 of the Mental Health Act.

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.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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 one section 47 certificate in place that was detailed, with a treatment plan in place. We were pleased to see that staff had recorded the specific relevant section of the AWI Act in the person's file and on the patient information board in the staff duty room.

Rights and restrictions

The door to the ward was open and we were told that the door remained open, and that there were only occasional circumstances where the door had to be locked. Individuals we spoke with were aware of this.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on individuals 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 two individuals who had been made specified and the paperwork was in place. However, the most recent paperwork was on the electronic system, but not in the current paper file. We discussed this further with SCN and consultant psychiatrist and were advised that the current documentation should be printed off for the file.

The ward continues to have good links with the local advocacy service that is based in the Royal Cornhill Hospital. We were able to see from reviewing files, where

individuals had support from an advocate at review meetings and tribunals. When we reviewed files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under s275 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 wanted to find out how the ward was implementing the recommendation that we made on last year's visit. We were pleased to see that several individuals had opted to make an advance statement and that the ward had introduced these discussions as part of the individuals ongoing care and treatment.

Activity and occupation

Many of the individuals in the ward had spent long periods in hospital which had significantly affected their skills and abilities that would be required to live back in the community. We would therefore expect a specialist inpatient rehabilitation service to have individualised activities to promote recovery, demonstrated by activity planners/timetables to help individuals gain, or regain the skills and confidence needed to progress their recovery, where able.

The ward continued to have dedicated input from OT to provide therapeutic-based activities on a one-to-one basis and in groups. Individuals were able to tell us about community groups such as the walking group or attending the gym.

The ward had an activity nurse who worked across two wards. We saw available activities written on the board displayed in the ward corridor. Individuals that we spoke with were able to show us their weekly planner and told us about the range of activities they were participating in and the groups they attended.

When reviewing the care records, we found comprehensive recordings by the OT, which included assessments, along with detailed interventions that were required to support the individual with the task. Those that we spoke with, including staff, told us about the groups that were on offer, such as breakfast, lunch, art, and community groups. Individuals continued to benefit from the rehabilitation kitchen that was completed in 2022 and again, we heard from staff and individuals about the benefits of having this facility on the ward which supported patients in regaining their skills around this activity of daily living.

Individuals told us about their planned shopping in order to prepare and cook their meals which they enjoyed. Where individuals did not wish to engage in some of the identified plans, we found that the level of activity in their care was limited.

The physical environment

The layout of the ward consisted of shared dormitories and single en-suite rooms. There was a separate dormitory for males and females and the single rooms tended

to be allocated based on the needs of the individual. Some individuals we spoke with told us that they did not mind sharing a dormitory, whilst others told us that it could be noisy and lacked in privacy. There were showering facilities in each dormitory.

We heard from staff that due to some people being in hospital for an extensive period that there was not a lot of storage space for people's belongings, and they told us how some individuals required support to maintain their rooms and/or bed space areas from becoming too cluttered.

There were amenities for individuals to do their own washing, although the laundry room was off ward and shared with another ward. The ward had a small pantry room where individuals were able to make a hot drink and store some food in a refrigerator.

The ward had a large dining/lounge area where individuals could choose to have their meals. There was also a television and a pool table in this area, which led out to an enclosed and well-maintained garden and again, we heard on this visit that the nursing and OT staff had continued to support individuals with growing vegetables. There was also a quieter lounge that individuals were able to enjoy.

On the day of the visit, we were disappointed to see the garden was being used by people for smoking. We asked the SCN about this, given that it is against the law to smoke or allow smoking within 15 metres of a hospital building in Scotland. NHS Grampian have a no smoking policy in place, and we were told that senior managers were reviewing the policy.

Recommendation 4:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

Summary of recommendations

Recommendation 1:
Managers must ensure that care plan reviews are detailed and meaningful and that these reviews are consistent across the ward.

Recommendation 2:
Managers must ensure that risk management plans provide detail as to how risks are to be managed for individuals and ensure that these are regularly reviewed as part of the MDT meetings and rehabilitation review meetings.

Recommendation 3:
Managers should implement a standardised multidisciplinary framework for reviewing individuals' care and treatment in the rehabilitation setting, such as CPA or ICP.

Recommendation 4:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

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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