Mental Welfare Commission for Scotland

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

Date of visit: 12 March 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

Skene Ward is a 16-bedded, mixed sex unit that provides care for individuals who have a diagnosis of dementia and can experience a level of stress and distress behaviours; the ward is on the main Royal Cornhill Hospital site. The ward offers single room and dormitory accommodation for 16 individuals, and we heard from managers that there were also two surge beds in the ward, to manage any crisis admissions.

On the day of our visit, there were 18 people on the ward, with no vacant beds and both surge beds were being used.

We last visited this service in October 2023 on an announced visit and made no recommendations.

On the day of this visit, we wanted to follow up on the introduction of the protocol for managing the reporting procedures for individuals who were medically fit for discharge, but a suitable placement was not available. This had been recently introduced at our last visit, and we were keen to hear about any impact this had made on the number of individuals experiencing delays.

Who we met with

We met with, and reviewed the care of eight people, five who we met with in person and eight who we reviewed the care notes of. We also met with five relatives.

We spoke with the service manager, the senior charge nurse (SCN), the nurse manager, nursing staff on duty and the consultant psychiatrists.

Commission visitors

Susan Hynes, nursing officer

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

All the individuals in Skene Ward appeared comfortable, with little sign of stress or distress and seemed well cared for. We observed supportive and attentive care being provided directly to individuals. When a relative visited, staff were quick to greet them and offer the individual a space to meet. Staff appeared responsive to individuals' needs.

Positive relationships were obvious, and it was evident the staff group worked well together and knew each person's needs, responding proactively to any distress or agitation.

We spoke with five relatives and in the main, we received very positive feedback about the care provided from them. We heard that staff were "caring", "understanding" and knew the people in their care well. We heard that relatives felt "confident" that their loved one was receiving the best possible care. Relatives commented positively on communication and told us that staff were proactive in contacting them if there were any changes or concerns in relation to their relative.

One person spoke of the improvement in their relative following admission, which they felt was due to the person-centred way they were nursed, and they were less distressed. Other positive comments from relatives were that they felt "involved in their family member's care."

We discussed how the protocol for managing the reporting procedures for individuals who were medically fit for discharge, but a suitable placement was not available had impacted on delayed discharges. The nurse manager and senior charge nurse were both positive about the process and explained how Health Improvement Scotland (HIS) were supporting improvement work in this area. There was a test of change currently ongoing which was showing positive benefits in reducing delays in transfers of care and discharges. They described a member of the HIS team who supported the daily huddle, which included a focus on the flow of people across the hospital and the identification of delays and consideration of possible solutions. This had proved effective, and the ward reported a reduction in individuals experiencing delayed transfer to a suitable environment.

Care, treatment, support, and participation

Care records

E-health records had been recently introduced into Skene Ward, and care records were held in both paper and electronic format, with the electronic format held on TRAKCare.

We found some records had more information in the paper notes while others had similar information in electronic format. This could mean that information is missed, or staff might not know where to locate information they needed to care effectively

for individuals. We would hope when we next visit, there will be a more consistent approach to care records and information storage.

We found that care plans were easy to locate in the individual's paper folder. We found well written and detailed care plans; they incorporated all physical, mental health and emotional care needs for the individual, but there was a lack of consistency in the person-centred approach with some care plans focussing on tasks.

We found completed 'Getting to know me' (GTKM) documentation in all of the files we reviewed, and this was used to inform some care plans. GTKM is a document that collates information on an individual's needs, likes and dislikes, personal preferences and background, to enable staff to understand what was important to the individual and how best to provide person-centred care while they are in hospital.

The care records showed regular one-to-one sessions with individuals and staff, and the records clearly evidenced how daily care and activity linked to care plans.

There was evidence that care plan outcomes were reviewed in a timely way, but the reviews lacked detail, and we spoke at the feedback session at the end of the visit with staff about how these could be improved by focusing on the improvements individuals had made during their period of care, measured against the proposed outcomes with care plans updated accordingly.

Recommendation 1:
Managers should ensure that nursing staff include summative evaluations of care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

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.

For some individuals, the Newcastle model was used and there were psychological formulations in these care records, where more specialist plans for managing stress and distress had been planned by psychology. These plans were readily accessible for all staff to help understand and support the individual in the most appropriate and helpful way.

We found rapid risk assessments completed for individuals who had been in other wards in Royal Cornhill Hospital prior to admission to Skene Ward. These helped identify risks but had not been reviewed since the individuals' admission, and we were told Skene Ward did not use this risk assessment. We identified some

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

individuals with detailed risk assessments and management plans that were stored on TRAKCare but in other people's care records, these had not been completed. We were concerned there was not a consistent risk assessment and management plan being used in the ward

Recommendation 2:
Managers should ensure a consistent and robust approach to risk assessment and risk management for all individuals in Skene Ward.

Multidisciplinary team (MDT)
A range of professionals were involved in the provision of care and treatment in Skene Ward. This included registered nursing staff, health care support workers, consultant psychiatrists, a general practitioner (GP), and an activities support worker, who had recently been appointed but was not yet working on the ward.

Occupational therapy (OT), physiotherapy, psychology and speech and language worked across the service and their involvement was available dependent on individual care needs. The OT and physiotherapist also provided group activities in the ward that all individuals could access if appropriate.

We were told that there was a fairly stable staff group, however, the staff were often redeployed to other wards where there was a staffing deficit. This could result in the senior nursing team being unable to fulfil the leadership duties fully as they were required to supplement the staffing numbers. This had caused some difficulties with the senior nurses being unable to introduce and complete audits, and to fully develop the nursing leadership team in the way they had hoped to.

We heard that MDT meetings were held every week along with daily huddles, which were brief and focused meetings. We reviewed the MDT meeting recording template on TRAKcare. The template contained prompts which would allow a holistic summary of the meeting discussion, however we found that it was inconsistently completed.

We were pleased to see information such as the date of the meeting, names of those attending the meeting, the person's legal status and individual/family involvement being completed for every meeting. Although we saw evidence of relatives being asked questions and meeting with nursing and medical staff, we did not see them always being fully involved before, during or after the MDT meeting. We heard from people and relatives that they were not routinely invited to MDT meetings but felt involved in their relative's care and that they had input into decisions.

Additionally, there were two senior nurses from the community mental health team in Aberdeen City who attended the team meetings to support discharge and transitional care. We were told how there was good attendance from social workers and mental health officers at reviews where the individual stayed more locally.

However, this could be challenging for social work staff in more remote or island areas. We discussed consideration of virtual attendance at these meetings which is something the ward may explore.

Use of mental health and incapacity legislation

On the day of the visit, 12 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

Advocacy services were available in the ward and individuals and carers were supported to access this. Where individuals had a named person, guardian or attorney they were appropriately involved in treatment decisions and given information both verbally and in written format about their relative's legal status.

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment were kept in either the legal paperwork folder or the individual's personal folder. All documentation was up-to-date, clear with excellent plans of care.

During the visit we heard that all patients were subject to "AWI" and this phrase was used in individuals' care records and care plans, meaning the AWI Act. This terminology can give rise to some confusion in relation to what legal authority is in place for an individual patient. Being subject to the AWI Act could mean that there is a section 47 certificate, a power of attorney or that a welfare guardian has been appointed, and we would urge services to be specific about what which measures under the AWI Act are in place.

This would enable clarity around the existing legal authority for people. We did find that individuals had the relevant documentation in their files or legal document folder with current section 47 certificates, guardianship powers or power of attorney documents available. The service should ensure this information is easily available for staff providing care for the individuals and is reflected appropriately in the care records and plans.

We noted that this was recorded on the main notice board that staff used, where individuals were subject to detention under the Mental Act and would suggest that it may be helpful to highlight in a similar way those who have a power of attorney or welfare guardianship in place.

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 corresponded to the medication being prescribed.

T2 and T3 certificates were kept in either the legal document folder or in the person's individual file. This was easily accessible but could cause confusion, and a consistent place to keep the certificates would enable staff to easily identify and check that legal authority to give treatment was in place.

Recommendation 3:
Managers should ensure there is an agreed approach to the filing of legal documentation, with T2 and T3 certificates kept in an easily accessible format for staff prescribing and dispensing medication.

Two informal individuals had intramuscular (IM) medication prescribed (in both cases this had been prescribed when they were subject to a short-term detention certificate). The Commission considers that it is not good practice for IM "as required" psychotropic medication to be prescribed for agitation for people who are informal as it would indicate there is not consent and may involve restraint. We were reassured to see that neither individual had been given this medication while they were informal. This was discussed with the responsible medical officer (RMO) on the day and was discontinued.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a person had nominated a named person, we found there had been involvement and discussion about their care and treatment.

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 all individuals had medical treatment being authorised by a section 47 certificate on the basis that they had been assessed as lacking capacity to consent to treatment. We found excellent treatment plans and appropriate involvement of guardians, attorneys and/or next of kin in these documents.

For people who had covert medication in place, all appropriate documentation was in order and had detailed recording of reviews and the pathway where covert medication was considered appropriate. The Commission has produced good practice guidance on the use of covert medication.[2]

Rights and restrictions

Skene Ward operated a locked door policy commensurate with the needs of the those cared for in this environment. Where restrictions were in place, these were

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

authorised by appropriate legislation and were in line with risks identified in individual risk assessments. The locked door policy was displayed in the ward along with a sign explaining this on the door.

The Commission has developed *Rights in Mind.*[3] 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

The ward was praised by carers for its clean environment and range of activities offered each day. We saw groups and activities including chair-football, art and nail care during our visit and relatives reported that there were always activities on offer.

Skene Ward was also visited regularly by a therapet. The ward nursing staff co-ordinated activities, as well as groups and activities led by the OT and physiotherapist. There had been an activity co-ordinator appointed to the ward and staff were hopeful this would enable increased access to the garden area. We look forward to seeing how this positively impacts on activities offered on future visits

Reminiscence/rehabilitation and interactive therapy activities (RITA) is an all-in-one touch screen system offering digital reminiscence therapy. We heard it was used by staff on the ward to support reminiscence sessions. We were also pleased to see that individuals who struggled to engage in group activities were offered individually planned activities in an environment that suited their needs.

The physical environment

The ward accommodation consisted of five single en-suite rooms and three shared dormitories, along with communal lounge and dining areas that were bright and spacious for individuals to move around. We saw that some individuals had brought in personal items to make their room or bed space more personalised. The SCN told us that there tended to be four individuals based in a dormitory however, this could increase depending on demand.

This ward had not been purposely built for people with a diagnosis of dementia, but efforts had been made to enhance the environment and improve it for this group of people and for the staff who were supporting them. There was decoration and soft furnishings that helped make a pleasant environment.

We heard the OT had carried out an audit which had been developed by the King's Fund specifically for environments of care for people with dementia. We were told this would be used to help develop a more supportive design for the people in the ward.

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

Skene Ward was situated upstairs and had access to a downstairs garden. We heard on previous visits there had been issues with the lift breaking down, which had an impact on access to the garden and that it had been difficult to maintain. We were pleased to see the improvements that had been made to the garden area and the plans for its use in the warmer weather. We saw information about local services on notice boards both inside and outside the ward area and about the work of the Mental Welfare Commission.

Summary of recommendations

Recommendation 1:
Managers should ensure that nursing staff include summative evaluations of care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 2:
Managers should ensure a consistent and robust approach to risk assessment and risk management for all individuals in Skene Ward.

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Managers should ensure there is an agreed approach to the filing of legal documentation, with T2 and T3 certificates kept in an easily accessible format for staff prescribing and dispensing medication.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk

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