

Mental Welfare Commission for Scotland

Report on unannounced visit to: Davan, Muick and Skene wards, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH

Date of visit: 15 May 2018

Where we visited

Davan is a 16-bedded dementia assessment ward. Muick is a 24-bedded mixed-sex functional assessment ward for Aberdeen city, Orkney and Shetland. Skene is a 23-bedded functional assessment ward for older adults in Aberdeenshire. We last visited this service on 31 August 2017 and made recommendations in the following areas: use of an index page for mental health act information, including current detention status and a record of all other forms in use; and the monitoring of ward temperature. On the day of this visit, we wanted to follow up on the previous recommendations.

We were pleased to see many Mental Welfare Commission good practice guidance booklets on display in the nursing station in Davan, together with helpful information for staff in recording one-to-one time with patients.

Who we met with

We met with and/or reviewed the care and treatment of 13 patients, and met with one relative.

We spoke with the charge nurses and other clinical staff.

Commission visitors

Douglas Seath, Nursing Officer

Ian Cairns, Social Work Officer

Dr Mike Warwick, Medical Officer

Dr Natalie Jeffrey, Temporary Medical Officer

What people told us and what we found

Care, treatment, support and participation

Patients we met with were very positive about nursing staff in the ward and spoke specifically about them being kind, supportive and approachable.

Of the mental health care plans we observed, some were person centered and quite detailed, whilst others, especially in Skene, were fairly generic. There was also a lack of evidence of evaluation of the interventions documented. Mostly, written entries were dated but no change indicated. Moreover, where there were major changes to a patient's condition, we did not find a corresponding review of assessed risk.

Multi-disciplinary team meetings were documented, sometimes lacking information about who attended, but most records were complete.

Skene ward was particularly short staffed on the day of the visit and this was an issue also observed by patients to be a regular occurrence. One patient indicated that this meant her sometimes having to wait longer for assistance with personal care.

There were issues about the patient mix in Muick ward. Twenty-two beds were occupied on the day and eight of those patients had dementia. We were told there can be incidents because most beds are in dormitories and inevitably, there were patients with cognitive impairment and patients with functional illnesses sharing the same dormitory.

Skene ward admits people with dementia for further assessment if they are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) and need more intensive nursing than the community dementia assessment units can provide. Some patients reported frustration when another patient approached them repeatedly, or became very vocal and distressed with no staff around. This was not necessarily always in relation to patients with dementia.

Staff also reported that, at times, the clinical needs of patients with dementia meant they could not give sufficient individual time to other patients. We understand there has been difficulty recruiting nursing staff to Royal Cornhill, but were concerned to hear this may be affecting patient care.

Many patient files had 'Getting to Know Me' forms, and in most files some personal life history information was recorded in the Mental Health Nursing Care Document. However, a significant number of patients had been in hospital for a lengthy period and there was a lack of personal life history information available.

Due to a member of staff leaving, there was no dedicated occupational therapy (OT) input to Davan ward, though there was a staff member available to the ward one day per week. This led to a reduced input available for assessment and structured activity provision. However, the access to psychological therapies was good and one patient in Skene was particularly benefitting from this service.

Relatives of patients in Davan ward were able to meet with the psychiatrist by arrangement, following discussion with nursing staff, generally around preparing for discharge but could be on a more regular basis. This was an improvement on the situation on our last visit.

Recommendation 1:

Managers should ensure that care plans are person centred, evaluated and that, where there has been significant change to a patient's circumstances, risk assessments are reviewed and updated.

Recommendation 2:

Managers should ensure that, where there are staffing shortages, appropriate action is taken to prevent this impacting on patient care.

Recommendation 3:

Managers should ensure that where there are patients with dementia and those with no cognitive impairment in the same ward, a protocol is in place to assess the suitability of patients to share a dormitory.

Use of mental health and incapacity legislation

In Davan ward, patient files contained an index page to help locate relevant documentation under the Mental Health Act.

The majority of consent to treatment forms were in place and appropriate for patients detained under the Mental Health Act. However, there was one case in Muick where medication was not properly authorized, as appropriate legal authorisation should have been in place before administration by way of a T2 consent to treatment form. This had also been noted by the pharmacist during a routine audit. In Skene we found two patients receiving medication not authorised by either a T2 or T3 form. We followed these up on the day and the doctors agreed to correct the errors.

The covert medication pathway was utilised appropriately in Davan Ward and all patients lacking capacity had s47 Adults with Incapacity (Scotland) Act 2000 certificates and treatment plans on file.

Rights and restrictions

There were issues with patients with dementia in Muick in relation to the number of falls, with 13 patients identified as posing a falls risk. There had been a recent review to look at installing tele-care e.g. bed, chair and door sensors and possibly other technology in the ward. The view was that this may reduce the number of falls and mean that the ward door will be able to be left open more frequently. The Commission would be interested to hear about the outcome of this review and, if adopted, the success of the change in monitoring arrangements.

There was information about the locked door, and a copy of the policy, available in Muick but not in Davan Ward. However, managers said that, owing to the number of posters now in place, they were reviewing the amount of information located near the entrance to the ward to prioritise essential items.

Activity and occupation

There did seem to be good activity provision in Muick Ward including: exercise groups; quizzes; knitting; and art groups. In Davan Ward, the activity programme, mainly run by nursing staff, took place in the afternoons. Popular activities included bowling,

pampering, singing and activities based on occasional or seasonal events. In Muick, there was a great deal of enthusiasm to develop activities and some fund raising events were taking place to facilitate this. The main aim of fundraising was to have an internet café based in the ward which would provide patients with the ability to Skype or use the internet to have contact with relatives and family, and they have already raised a large part of the money needed.

Of the three patients interviewed, one chose not to engage in many activities and his main activity was going out to shop; the other two said that there was good activity provision.

The OT staff organised groups on Skene Ward, for example, a newspaper group and art group, but there was no timetable displayed. The nurse in charge said she did not know when the OT's would provide this. The physiotherapist offered an exercise group. Nurses also provided activities, but this relied on adequate staffing levels. There were also support staff available on the day provided by in-reach from the intensive support service. This had enabled some patients to, for example, go to the beach.

The physical environment

The ward environment in Davan was much improved, with dormitories and single rooms provided with individual wardrobes and bedside cabinets. These have been personalised to a degree, but patients need to have items locked away to stop things being mistakenly taken by patients with cognitive impairment. The corridors, dining room, sitting room and garden were all dementia friendly with good signage, albeit mainly in word format on laminated temporary notices, pictures and tactile objects. There were no issues raised about the temperature of the ward.

Having only two showers on Davan and Skene wards, was proving impractical to enable all patients to bathe at their desired time. However, it is difficult to see how this could be remedied within the current ward environment. Some patients in the dormitories also felt that one toilet between six patients was insufficient.

Summary of recommendations

1. Managers should ensure that care plans are person centred, evaluated and that, where there has been significant change to a patient's circumstances, risk assessments are reviewed and updated.
2. Managers should ensure that, where there are staffing shortages, appropriate action is taken to prevent this impacting on patient care.
3. Managers should ensure that where there are patients with dementia and those with no cognitive impairment in the same ward, a protocol is in place to assess the suitability of patients to share a dormitory.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Alison Thomson
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 MWC 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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