

Mental Welfare Commission for Scotland

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

Date of visit: 29 January 2019

Where we visited

Strathbeg Ward is a 12-bed ward providing care for men with progressing dementia and associated symptoms of stress and distress. We last visited this service on 13 June 2017 and made a recommendation that managers should ensure that, where applicable, all patients who would benefit from having a completed Life Story should have one completed within six months of admission.

On the day of this visit we wanted to meet with patients and carers, follow up on the previous recommendations, and look at how the closure of Loirston Ward had impacted on the care and treatment of patients who would normally have been admitted there.

Who we met with

We met with and/or reviewed the care and treatment of eight patients, and spoke to three visitors.

We spoke with the charge nurse, consultant psychiatrist, and other clinical staff.

Commission visitors

Douglas Seath, Nursing Officer

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

On the day of the visit, we were welcomed into the ward and all patients appeared very well cared for and were smartly dressed. The atmosphere in the ward was calm, with organised activities taking place. Staff were observed engaging well with patients and were clearly enthusiastic about their work.

Staff indicated that the closure of Loirston Ward had initially created additional pressure. However, the closure did allow the ward to increase their nursing staff ratio to the full complement, and they did not have any delayed discharge patients on the day of the visit. It had also led to the creation of a waiting list for patients to be admitted.

Patient records were well organised and maintained, with a clear index at the front of the file, and information was easily located. Risk assessment and management plans were present, forming the basis for care plans which were of a very good standard. The format of the care plan was clearly structured, with care goals, any barriers to achieving goals, and actions or interventions required of nursing staff.

Plans were detailed and person centred, and there was a clear connection between specific goals, interventions, and how the individual would achieve this with the

support of nursing staff. Plans were also reviewed regularly - although often this was generally recorded as a date when a review took place, without the necessary detail of any evaluation of care being delivered.

Care plans were recovery focussed with goals written to incorporate this, including those relating to stress and distress. The individuals' plans, which detailed how staff would provide support when a patient became agitated or distressed, were particularly good. In all the files reviewed there was a stress/distress care plan, and these had very clear information about the individual person, about the way they might exhibit symptoms of stress or distress, and about the approaches which could help to reduce agitation. Where appropriate, the stress/distress care plans were accompanied by specialist assessments, and the guidance prepared by the occupational therapist or by the clinical psychologist.

The regular multidisciplinary team (MDT) reviews were also well recorded, with information about people who attended these reviews, some information about any changes in care and treatment needs since the previous meeting, and clear action points agreed.

Recommendation 1:

Managers should ensure that when care plans are reviewed, there is documented evidence of the evaluation of the success or otherwise of the interventions. This information is needed to give an indication of the effectiveness of the care plan.

Use of mental health and incapacity legislation

We found paperwork in relation to patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) was up to date, and easy to locate within files. We reviewed certificates authorising treatment (T3). The prescriptions were completed in accordance with the medication authorised by the designated medical practitioner (DMP).

The majority of patients had previously granted powers of attorney, or were subject to welfare guardianship. This was well recorded in files, with copies of the powers also present. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (AWI Act) must be completed by a doctor. In all the files, where appropriate, reviewed s47 certificates were in place. Every s47 certificate had detailed treatment plans, with information about conditions for which treatments were being prescribed.

In the files that we reviewed there were do not attempt cardiopulmonary resuscitation (DNACPR) forms in place, with information about relatives who were consulted before this decision was taken.

Rights and restrictions

The door to the ward was locked on the day of our visit, but information about the locked door policy was clearly displayed. It was also clear in file reviews that the door was locked because of quite specific clinical needs.

The use of covert medication pathways was noted in some of the files we reviewed. The information in each patient's record was comprehensive and met the legal requirements of the AWI Act. The covert medication pathway was found in the patient file, and a copy was kept with the medication prescriptions.

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/rights-in-mind/>

Activity and occupation

One of the two part-time ward activity co-ordinator posts was vacant at the time of the visit, but plans were underway to provide a replacement. Many patients had limited concentration to be able to focus on group activities, but some were engaging individually in artwork and board games with staff during the visit.

In addition, the occupational therapist attended three days per week. There was also evidence of the active involvement of specialty doctors, physiotherapy, clinical psychology, speech and language therapy, and a dietitian.

The physical environment

The ward felt quite spacious for a 12-bedded unit, with a combination of single rooms and dormitory accommodation. Work has been done, involving relatives, to look at the physical environment, and at how this could be made more dementia friendly. This resulted in information and signage displayed in the ward being reduced and simplified, to make the environment less cluttered.

There was an enclosed garden area which provided an opportunity for patients to access fresh air, and opportunities to be involved in practical work like planting the raised beds.

The one difficulty nursing staff had was the lack of access to an assisted bath for patients who preferred this to a shower. The bath currently in place was over 20 years old and could not be used. Funding was needed to replace this.

Recommendation 2:

Managers should ensure funding to replace the assisted bath at the earliest opportunity, so that patients who became distressed in the shower have the option of taking a bath.

Any other comments

Strathbeg Ward is one of four demonstrator sites in Scotland which are working with Healthcare Improvement Scotland (HIS) as part of a specialist dementia unit improvement programme.

It was clear from speaking to staff on the day that they were positive about the developments that have taken place, and could see real benefits in the way the provision of care and treatment in the ward was developing.

One example is that Strathbeg Ward has introduced a ceiling of treatment approach, which looks at how care and treatment is provided in the ward when a patient's condition is deteriorating. They also have fall review documentation, to identify preventive action or steps which can be taken to reduce risk of falls. Family communication is seen as vital, and the approach adopted focusses on family members and ward staff working together. There is documentation of this collaborative approach in each patient file, and this was supported by discussions we had with carers on the day of the visit.

Summary of recommendations

1. Managers should ensure that when care plans are reviewed, there is documented evidence of the evaluation of the success or otherwise of the interventions. This information is needed to give an indication of the effectiveness of the care plan.
2. Managers should ensure funding to replace the assisted bath at the earliest opportunity, so that patients who became distressed in the shower have the option of taking a bath.

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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