

**Mental Welfare Commission for Scotland**

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

**Date of visit:** 30 April 2019

## **Where we visited**

Huntly Ward is an adult admission ward providing inpatient care and treatment for both men and women between 18 and 65 years of age. The ward has 25 beds, with a combination of four dormitories and five single rooms. Patients are referred for assessment from the Aberdeen city area.

We last visited this service on 9 October 2018, at which time we made recommendations about care plans, consent to treatment forms, specified persons, ward environment, and access to clinical psychology. We received an appropriate response from the service about the recommendations.

On the day of this visit, we wanted to look again at some of these issues, meet with patients and visitors, and also other concerns which had been brought to the attention of the commission by family members and visitors to the ward.

## **Who we met with**

We met with and reviewed the care and treatment of seven patients.

We spoke with the senior charge nurse, and other nursing staff involved in the patients' care and treatment. As the visit occurred out of hours, other staff were not available to meet with on the day.

## **Commission visitors**

Alison Thomson, Executive Director (Nursing)

Douglas Seath, Nursing Officer

Moira Healy, Social Work Officer

Dr Juliet Brock, Medical Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

#### **Patient involvement and participation**

Patients who met with us on the day of the visit were generally satisfied with the care and treatment provided on the ward and with the support provided by staff. We heard several comments from patients about how they felt staff in the ward were approachable and helpful and responded well when patients needed to speak to them. However, although the number of nurses on duty were adequate, staff and patients reported there is a difficulty in finding space to meet privately. Relatives and visitors also had similar concerns.

We noted that one-to-one contact between nursing staff and patients was well recorded in daily progress notes. We also saw that multi-disciplinary team (MDT) reviews continue to be well recorded, with good information about who attends these MDT meetings and about decisions taken at the meetings. Some patients reported meeting with staff one-to-one prior to meetings to air their views which were then represented at the MDT meeting with any actions or changes to treatment relayed back following the meeting. We found it difficult to see evidence in many files that patients had actively participated in developing their individual care plans and many were unsigned. Patients did not regularly attend the weekly meetings. There were mixed views about access to medical staff, with patients more recently admitted having more frequent meetings.

Patients have a 'getting to know me' document and this is helpful in providing information about past life and interests, encouraging a more person-centred approach.

### **Care planning and documentation**

When reviewing the patients' care plans, we noted the useful and detailed initial nursing assessments were completed within 24 hours of admission and were of a high standard. We also saw evidence of good risk management and clear management safety plans with evidence of review taking place. However, we found variation in terms of the quality and the completion of the interventions in care plan documentation.

In some files, care plans were detailed and person-centred, with regularly updated descriptions of nursing interventions and evidence of review and evaluation. In other files, we felt that information about an individual patient's needs and treatment goals were combined. Needs were recorded in one general care plan, when it would have been more appropriate for there to be several individual care plans relating to separate and quite specific needs. The staff we spoke with felt their ability to record information is constrained by the limited space available in the Grampian admission booklet in which care must be documented.

There was good attention to assessment of physical healthcare needs with a full medical assessment on admission with regular physical health checks, monitoring and referral to specialist services if required. However, where there were specific physical healthcare needs identified, there was not always a care plan to detail the interventions required by staff.

### **Recommendation 1:**

Care plans need to be person-centred and contain sufficient information for care to be delivered in this way. Managers should review the care plan documentation, to ensure there is adequate space for the necessary detail to be recorded.

## **Use of mental health and incapacity legislation**

The Mental Health (Care & Treatment) (Scotland) 2003 Act ('the Mental Health Act') detention paperwork we reviewed highlighted an area of concern. We examined the drug prescription sheets and treatment certificates which should be in place to authorise medication when a patient is detained and when medication has been prescribed on a compulsory basis for more than two months. A consent to treatment (T2) or certificate authorising treatment (T3) form requires to be in place to authorise medication prescribed in these circumstances.

During the visit, we found five patients whose medication was not authorised by their consent to treatment forms, one of those having no form in place, and one whose form had expired several months previously and who was not consenting. This was discussed with the ward manager during the visit to initiate legal authorisation and escalated to the associate medical director due to the recommendation from the previous visit not being met.

### **Recommendation 2:**

Managers should introduce an audit tool and identify who will monitor consent to treatment documentation to ensure that all treatment is legally authorised. We will review that the recommendation has been implemented after three months.

## **Rights and restrictions**

The door to the ward was locked due to level of clinical activity and number of patients subject to detention under the Mental Health Act. However, none of the patients we met with described any problems with exit or entry to the ward.

There was good advocacy input into the ward, with staff encouraging referrals for advocacy support.

Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient 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.

The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

Currently any patients who were specified persons had appropriate paperwork in place.

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**

We heard that activity provision in the ward was generally good and the timetable of structured activity provision was displayed in the ward. Patients can also access activities at the recovery resource centre within the hospital and by attending groups run by the occupational therapist. This includes artwork, a breakfast group, baking and walking groups.

There was a link nurse identified per shift to arrange activity input to the ward, but this is not protected time and so activity provision is dependent on clinical activity within the ward.

## **Ward environment**

Patients and visitors found the available space to be cramped in relation to the number of patients in the ward, and staff reported that they were constantly full to capacity. Staff also reported that, due to the reduction in overall bed capacity within the adult assessment wards in the hospital, patients admitted were generally more acutely unwell than previously. This has led to more frequent altercations and disagreements between patients. Although staff intervened to settle disputes, visitors observed that staff were not always present in the day area at the times that incidents arose, though observation was possible from windows to the duty room.

Work was carried out on the ward last year to reduce potential ligature risk and this included the removal of doors from wardrobes. Patients commented that there is nowhere to hang clothes in the bedrooms and there were reports of possessions going missing in the dormitories. Patients also had no direct access to a garden, the ward being situated on the first floor. However, patients could access a garden on the ground floor by going outside into an area adjoining another part of the hospital.

There was limited provision of visiting facilities for meeting in private, with most meetings taking place in the sitting room or, if patients are able to leave the ward, in the café. One of the staff areas has been designated as a meeting room for visitors out of hours but can only realistically provide space for one group at a time and we noted that this led, at times, to the formation of a queue for its use. Another staff room is available but is outwith the ward environment. Visitors commented that they felt that they were in competition with staff for use of the available space.

Due to the multiple and frequent use of rooms within the ward, patients and visitors commented that the cleanliness of the environment and provision of supplies became more problematic as the day progressed.

### **Recommendation 3:**

Managers should review the use of available space for the number of patients being treated to ensure that care can be delivered in a patient centred way with adequate privacy.

### **Any other comments**

Since the closure of one of the acute admission wards last year, occupancy has remained high, with patients generally having a higher level of need and nurses reporting greater levels of adverse incidents than previously. However, at the time of the visit, only one patient required continuous intervention. Nevertheless, staff reported that there is a high turnover of patients, with 18 of the 25 patients subject to compulsory treatment under the Mental Health Act. Although the ward has good nurse staffing ratios, many of the staff are new and inexperienced, requiring a higher degree of supervision in their work, thereby putting additional responsibilities onto the remaining registered nurses.

### **Summary of recommendations**

1. Care plans need to be person-centred and contain sufficient information for care to be delivered in this way. Managers should review the care plan documentation, to ensure there is adequate space for the necessary detail to be recorded.
2. Managers should introduce an audit tool and identify who will monitor consent to treatment documentation to ensure that all treatment is legally authorised. We will review that the recommendation has been implemented after three months.
3. Managers should review the use of available space for the number of patients being treated to ensure that care can be delivered in a patient centred way with adequate privacy.

### **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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