

**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:** Forensic Acute and Rehabilitation wards, Royal Cornhill Hospital, Aberdeen

**Date of visit:** 8 December 2015

**Date sent to service:** 20 January 2016

## **Where we visited**

We visited Forensic Acute and Rehabilitation Wards, Royal Cornhill Hospital. Forensic Acute and Forensic Rehabilitation wards are situated within the Blair Unit at Royal Cornhill Hospital. Forensic Acute is an 8 bedded ward and Forensic Rehabilitation is a 16 bedded ward.

We last visited this service on 3 December 2014 and made the following recommendation: details of restrictions authorised for specified persons should be available on the wards so that nursing staff can correctly apply the restrictions.

On the day of this visit, we wanted to follow up on the previous recommendation and also look at care planning and restrictions placed on patients. This is because it is a locked environment and because of issues we have identified elsewhere in the hospital.

## **Who we met with**

We met with six patients, and reviewed one further case file.

We spoke with the ward managers and other nursing and medical staff.

We didn't meet any relatives or carers on the day.

## **Commission visitors**

Douglas Seath, Nursing Officer, and visit co-ordinator

Jamie Aarons, Social Work Officer

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

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

We spoke with six people in the two units who told us about their experience of care and treatment. People we met with were positive about the care and support staff were providing, and about the contacts they had with staff. From our observations during the day of the visit, we noted that interactions between staff and people in the wards were positive and supportive.

Multi-disciplinary team meetings take place on a regular basis and these are minuted with a note of those in attendance.

There was evidence of good GP access and positive feedback from patients about their access to physical healthcare. Medical reviews by the psychiatrist also take place regularly and the files include a detailed record of these.

We were told about the rehabilitation ward being a pilot site for 'Triangles of Care', with all permanent staff trained in "Equal Partners in Care." They have an upcoming

carers' evening and carer feedback is sought on the ward in a variety of ways. They are currently working on a ward leaflet, including a specific one for carers. The mental health advocacy service is involved in 'Triangles of Care' and advocacy access on the ward appeared to be good.

The nurses' risk assessment is a thorough, holistic document. However, this did not always lead to person centred and appropriate care plans. Some care plans were not reflective of current risk and some patient files had no nursing care plans compiled. There was information about care being given but not in a structured nursing care plan as would be expected. We were informed these are under review at present and that a new system of care planning will be implemented.

### **Recommendation 1**

Managers should audit patient care plans for consistency in quality and individualisation and ensure that the care plans reflect and inform the care currently being provided.

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

There was a section of the individual file specifically for Mental Health (Care and Treatment (Scotland) Act 2003 (the Mental Health Act) documentation, but this did not appear to be used consistently and in at least one file contained out of date compulsory treatment order(CTO) forms (this was rectified on the day by medical records).

We also found there were issues regarding consistency of storage of other Mental Health Act documents. Mental Health Act consent to treatment authorisation forms (T2 and T3s) were mainly stored with medicine prescription charts which were well organised; and all but one of those examined were consistent with the medication prescribed. One minor amendment to a T2 was agreed with the doctor on the day. Where consent forms were absent from the medicine prescription folders, copies were located in the medical notes.

However, there were problems identified regarding relevant documentation in files in relation to specified persons. We were told that all patients in the rehabilitation and acute ward were specified persons. But two of the patients' records in the acute ward had out of date RES1 authorisation forms for safety and security, although it did not appear that any interventions had taken place during this time. This was brought to the attention of the ward manager on the day.

One patient was also noted to be incapable of managing his finances but the certificate authorising the hospital managers to carry out this function under part 4 of the Adults with Incapacity (Scotland) Act 2000 (the Adults with Incapacity Act) had expired in September 2014. This was raised with the nurse at the time of the visit.

These matters would be more easily identified by implementing an index of Mental Health Act and Adults with Incapacity Act status and review dates in each individual file.

## **Recommendation 2**

Managers should implement an index in patient files indicating Mental Health Act and Adults with Incapacity Act status, with review dates, to ensure reviews are lawfully completed within the required time limits.

## **Rights and restrictions**

It was noted that there are no forensic acute or forensic rehabilitation beds for female patients. At present, we were advised that there are four female forensic patients in Royal Cornhill Hospital Intensive Psychiatric Care Unit (IPCU). We did not visit this ward, but staff suggested that some patients are placed in IPCU inappropriately because there are no local female forensic inpatient services to meet their needs. Those patients may receive an inequitable service in that they do not subsequently have access to the rehabilitation pathway. This issue will be monitored in the Commission's next visit to IPCU.

## **Activity and occupation**

We found that patients had good access to occupational therapy (OT) and OT assistants. There was evidence that patients are going on outings to support their rehabilitation. This activity, however, was not consistently supported by care plans.

There was an issue raised by staff and two patients regarding the fact that the rehabilitation ward contains the main meeting room, which can be booked by other parts of the unit for use. This means that unknown people come and go from the ward and can impact on the rehabilitation ward staff's ability to access space within their own ward.

We were told that smoking restrictions have contributed to a reduction in staff's availability to support patients in activities or escorted passes. Due to the restrictions on the majority of patients on this ward, smokers require an escort off the grounds in order to smoke, and this is having an impact on the service as a whole. Currently, this is exacerbated by unfilled nursing vacancies and difficulty with recruitment.

## **Recommendation 3**

Managers should consider whether staff time spent escorting patients to smoke might be put to better use supporting smoke cessation and other more appropriate activities.

## **The physical environment**

The ward environment was clean and comfortable, though furnishings are fairly dated. Patient bedrooms were personalised and many benefit from having single rooms. The enclosed garden is referred to as 'the yard' and appears to be little used since the smoking ban was put in place. Due to a recent absconding by a detained patient gaining access to the roof via a bin, all furniture has been removed from the garden. This makes the garden appear less user-friendly, though staff told us that chairs can be taken into the garden from inside the ward.

### **Recommendation 4**

Managers should review the removal of all garden furniture and ensure that the outside area is once more made available as a sitting area for relaxation.

### **Any other comments**

One of the senior charge nurses advised that communication around transfers into the ward could be improved. Nursing staff would like greater clarity around transitions into the unit, as this can sometimes be a more confusing process than necessary (doctors approach the ward directly to admit one of their patients and this can cause confusion if more than one doctor has identified a patient for transfer).

## **Summary of recommendations**

1. Managers should audit patient care plans for consistency in quality and individualisation and ensure that the care plans reflect and inform the care currently being provided.
2. Managers should implement an index in patient files indicating Mental Health Act and Adults with Incapacity Act status, with review dates, to ensure reviews are lawfully completed within the required time limits.
3. Managers should consider whether staff time spent escorting patients to smoke might be put to better use supporting smoke cessation and other more appropriate activities.
4. Managers should review the removal of all garden furniture and ensure that the outside area is once more made available as a sitting area for relaxation.

## **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.

Kate Fearnley

Executive Director (Engagement and Participation)

18 December 2015

## 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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