Mental Welfare Commission for Scotland

Report on announced visit to: Fern Ward and Bracken Ward, Elmwood, Ashgrove Road, Aberdeen, AB25 3BW

Date of visit: 5 March 2019

Where we visited

Elmwood contains Fern Ward, which is a close supervision unit, and Bracken Ward which is an assessment and treatment unit.

Fern Ward was an eight-bedded unit which provides care for adults with a learning disability, who present with behaviour that can be harmful to themselves or others, requiring close supervision in a secure environment. At the time of visiting, Fern Ward had seven patients.

Bracken Ward is a 10-bedded admissions unit (temporarily reduced to seven beds) which provides assessment and treatment for adults with a learning disability who have a psychiatric illness, or present with behaviour which can be complex to manage. At the time of visiting Bracken Ward had two patients.

We last visited Fern Ward on 1 March 2016 and Bracken Ward on 7 January 2017 and made recommendations in Bracken relating to documentation, care plans and physical health care. In Fern we made recommendations relating to care plans, consent to treatment, and the physical environment. We subsequently received an appropriate response to the recommendations.

Who we met with

On the day of the visit we wanted to meet with patients and follow up on the response to recommendations made at our last visit.

In Bracken Ward we met with one patient and reviewed the files of both patients. In Fern Ward we met with four patients and one relative, and reviewed seven patient files.

We spoke with the nurse manager and the interim nurse consultant, charge nurse and other nursing and occupational therapy (OT) staff.

Commission visitors

Tracey Ferguson, Social Work Officer

Douglas Seath, Nursing Officer

Susan Tait, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

In both Fern and Bracken wards we found that patient files all had detailed personalised care plans and there was evidence of review of the care plans. All files had good background information about each patient and detailed risk assessments linked to the care plan. There was evidence of multidisciplinary meetings occurring

and care programme approach (CPA) meetings. There was evidence of patient participation in care planning and recording of this.

Physical health checks were evident in files and we were informed during our visit by the interim nurse consultant that they were looking at introducing new physical health check paperwork. This was to mirror the paperwork that was being used in the community teams.

The wards had a good admission pathway in place, and on our visit there were two patients whose discharge was delayed.

Individual files provided evidence that allied health professionals were involved to support a person-centred approach. There was good input from the OT team, who are based on site.

Use of effective communication strategies to engage this patient group and promote participation was evident. This included easy read version of documents, and pictorial activity planners. Speech and language therapy staff continued to have input and ward staff had been trained in using talking mats, and some were identified trainers.

Use of mental health and incapacity legislation

We were informed by the ward manager that a form had been introduced to prompt nursing staff to ensure recordings of legal documents were in the file. There was evidence of this in each patient file.

Where patients were subject to guardianship under the Adults with Incapacity (Scotland) Act 2000 ('The AWI Act') there was a copy of this in the file. 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. Section 47 certificates were present with attached treatment plans.

Certificates authorising treatment (T3) under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') were present and in patient files where required.

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.

We looked at all records involving individuals who had been made specified persons. Where one patient had been made a specified person, a RES1 form was in place.

However, there was no RES 3 form in place for the patient who was specified and restricted in relation to telephones. We would encourage wider use of the locally produced RES 1 form used in the Blair Unit, which had a reasoned opinion form attached. Our specified persons good practice guidance is available on our website.

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

As this issue was highlighted in our previous visit recommendations we will escalate this recommendation to the medical director.

Recommendation 1:

Managers should ensure all appropriate specified person paperwork is in place as appropriate.

Rights and restrictions

Across both wards, the majority of patients were subject to detention under the Mental Health Act or Criminal Procedure (Scotland) Act 1995.

Both ward doors were locked. However none of the informal patients were disadvantaged by this. On the visit, we observed that there was a notice on the inside ward door explaining to patients and families why the door was locked.

There were clear reviews of the levels of observations on a regular basis. Seclusion was used on occasions, but the ward did not have a seclusion policy 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/

Recommendation 2:

Managers should ensure a clear seclusion policy is in place where seclusion is being used. The service manager advised that where seclusion had been used, there was an individualised care plan/recorded documentation and a robust risk assessment in place for this which was reviewed on a very regular basis. The wider mental health service is also looking at a seclusion policy.

Activity and occupation

We saw examples of patient activity planners and the activity planners were individualised. The patients and ward staff benefitted from the OT team based on site. The pet therapy dog was in the ward when we visited, which patients were interacting with. For some activities the patients attended a separate facility at the Hawthorn building based within the grounds.

The physical environment

Bracken Ward

We were informed during our visit that Bracken Ward will be undergoing some refurbishment soon. One end of the ward could be used to provide a seclusion area, and when in use this could impinge on the available space for other patients.

Fern Ward

Fern Ward has had some refurbishment completed over the past 12 months, with all floors having to be replaced due to damage under floorboards.

On Fern Ward, the decor still appeared bland and uninteresting. Staff informed us that they had been waiting since the refurbishment to get pictures hung on the wall. We suggested that it may be more appropriate to use stencils on the walls as opposed to pictures that may be vulnerable to damage.

On Fern Ward it was observed that there was a noticeable echo when the ward was busy, and the new flooring may have contributed to this. It may be helpful to consider a sensory assessment of the ward environment, in order to determine what would be most suitable for individuals with autistic spectrum disorder.

Summary of recommendations

1. Managers should ensure all appropriate specified person paperwork is in place as appropriate.

2. Managers should ensure a clear seclusion policy is in place where seclusion is being used.

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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