Mental Welfare Commission for Scotland

Report on unannounced visit to: Fern Ward, Elmwood, Ashgrove Road, Aberdeen, AB25 3BW

Date of visit: 1 March 2016

Where we visited

Elmwood contains Fern: Close Supervision Unit and Bracken: Assessment and Treatment Unit. Fern is an eight bedded unit which provides care for adults with a learning disability who present with behaviour that is harmful to themselves or others, requiring close supervision in a secure environment.

We last visited this service on 17 March 2015 and made the following recommendations: the service should consider how patients' participation in care planning can be evidenced in the relevant documentation; issues with pictorial signs and lack of corridor window screening on Fern ward should be addressed.

We subsequently received an appropriate response to the recommendations.

On the day of this visit we wanted to follow up on the previous recommendations.

Who we met with

We met with 1 patient and reviewed a further 5 files.

We spoke with the service manager, the ward manager and other nursing staff.

Commission visitors

Douglas Seath, Nursing Officer

Paula John, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Care plans were detailed, personalised and linked with risk assessments. There was also evidence of patients' participation in care planning. The care plans would benefit from recording of this participation.

Continuity of care is a challenge with significant use of bank nurses unfamiliar with the patient group due to level of clinical activity and difficulty in recruiting and retaining nurses. There is good input from occupational therapy, speech and language therapy and clinical psychology staff. However, information is not always available as most allied health professional records are stored off site. Storage of records is under review and there are plans underway to try to co-locate records together.

Recommendation 1:

For ease of access to the complete records for each patient, the service should arrange for all records to be stored together.

Use of mental health and incapacity legislation

Although patient files contained a mental health act checklist, in many files this was incomplete and in others misplaced or missing altogether. There appeared to be no active audit of consent to treatment forms. Consequently visitors found one T3 form which was around four years old. Many of the forms were difficult to locate and few were available with the prescriptions. Visitors were also unable to locate any section 47 adults with incapacity act consent to treatment forms despite some patients lacking ability to consent.

Recommendation 2:

Managers should ensure compliance with consent to treatment requirements under the mental health act and adults with incapacity act by regular audit of patient files.

Rights and restrictions

Although the ward door is locked, none of the patients were disadvantaged as all are detained under the mental health act. Those patients who were specified persons had documentation in place and up to date reasoned opinion carried out by the responsible medical officer.

Activity and occupation

We saw several good examples of personalised activity timetables, many of these activities taking place on site. Patients have a good range of activities available to meet their needs.

The physical environment

We observed some issues with the environment on Fern ward. Much of the wall space is bare and, though there was clearly a painting programme in place, the decor appeared bland and uninteresting. Pictures and paintings are vulnerable to damage and, we were told, in certain circumstances may pose a risk of infection. However, visitors heard of the intention to add stencils to the walls to brighten corridors and rooms as the painting programme progresses.

The internal garden likewise is undeveloped and uninviting. Carpets in the corridors and communal space are damaged and need replaced.

The two windows at the end of the corridor on Fern ward remain unscreened and people passing by on the path could witness activity in the corridor and compromise patient privacy. This issue was highlighted in last year's report and remedial action promised.

Recommendation 3:

Funding should be identified to improve the ward environment in order to ensure patient privacy and to make it more stimulating for patients, some of whom may spend a significant period of time there. As this issue was raised at the previous visit, we will be bringing the matter to the attention of the head of learning disability services.

Any other comments

Visitors heard that there is the possibility of Elmwood wards being relocated to the Royal Cornhill Hospital site. It would be beneficial if this afforded patients an improved environment more suited to their needs. Although patient numbers have reduced over recent years, the communal space can still be cramped with everyone present.

Summary of recommendations

Recommendation 1: For ease of access to the complete records for each patient, the service should arrange for all records to be stored together.

Recommendation 2: Managers should ensure compliance with consent to treatment requirements under the mental health act and adults with incapacity act by regular audit of patient files.

Recommendation 3: Funding should be identified to improve the ward environment in order to ensure patient privacy and to make it more stimulating for patients, some of whom may spend a significant period of time there. As this issue was raised at the previous visit, we will be bringing the matter to the attention of the head of learning disability services.

Good practice

There was good evidence of Multi Disciplinary Team working. The patient care plans were very detailed and we saw one of the best behavioural management plans, although this was commenced on Bracken ward.

All patients have a good weekly structure of activity taking place in the Hawthorn day unit and there was good input from the occupational therapy service?

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

Douglas Seath, Nursing Officer 05 April 2016

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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk