Mental Welfare Commission for Scotland

Report on announced visit to: Royal Cornhill Hospital, Cornhill Road, Muick and Skene wards, Aberdeen, AB25 2ZH

Date of visit: 22 June 2016

Where we visited

On 22 June 2016, the Mental Welfare Commission visited Muick and Skene wards at Royal Cornhill Hospital on a local visit.

Muick ward is an assessment ward for older adults with mental health problems excluding dementia. Skene is an assessment ward for older adults with mental health problems including those with early stages of dementia. There are 47 available beds. On the day of our visit there were 46 patients on the wards. We had also planned to visit Davan ward, however this was temporarily closed for refurbishment.

We last visited this service on 9 July 2015 and made the following recommendations:

- There should be an audit to ensure activities continue regardless of staffing shortages
- Individuals should have opportunity to attend reviews
- Mental Health Act forms should be available in files
- There should be evidence of proxy powers

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

Who we met with

We met with and reviewed records of 12 patients.

We spoke with the directorate support manager, the nurse manager, lead nurse and ward charge nurses.

Commission visitors

Douglas Seath, Nursing Officer

Kate Fearnley, Executive Director (Participation and Engagement)

Juliet Brock, Medical Officer

What people told us and what we found

Care, treatment, support and participation

We reviewed the care planning and risk assessment documentation for the people we visited. Risk assessments were of a good standard and appropriate to the needs of the individual and presenting issues identified on admission. There were individual recovery care plans, however in most cases these did not identify the needs of the individual person, were lacking in detail, appeared generic and were not person centred. Additionally, evaluation of the care plans was not clearly documented in files

and gave little indication of the progress being made by the patient towards discharge.

The multi-disciplinary team (MDT) reviews were clear and detailed, with all attendees listed. Entries made by MDT members in the daily notes were comprehensive and we found the notes easy to follow. We saw one to one sessions documented by nursing staff and a record of refusal when an offer of a meeting had been made. Patients are not routinely invited to weekly reviews but are invited to the three monthly review meetings.

There is good pharmacy input into the units, with regular pharmacy involvement in the MDT reviews. A small number of patients were prescribed high dose antipsychotic medication, but high dose monitoring forms were not always complete or accompanying the patient drug chart. We would suggest that pharmacists assist the teams in ensuring this monitoring is carried out according to local protocols. There is also good occupational therapy (OT) input into the two units, both in activity groups and when requests are made for an assessment of particular daily living skills. SALT (speech and language therapy), physiotherapy and dietetic staff also contribute on a regular basis.

Do not attempt cardio pulmonary resuscitation (DNACPR) forms were in place, where appropriate, and relatives had been consulted in each case. Physical healthcare reviews were also up to date.

All patients assessed as being at risk of falls were issued with a pair of bed socks with gripping soles. We heard that this has led to a significant reduction in the incidence of falls, especially for patients trying to access the toilet during the night.

Recommendation 1

Managers should review care planning procedures to ensure that all individuals have person-centred care plans that are fully reviewed and evaluated regularly.

Use of mental health and incapacity legislation

Mental Health Act paperwork was well organised in files. However, where people were subject to compulsory measures, not all medication administered was authorised appropriately by a consent to treatment certificate (T2) or certificate authorising treatment (T3). We also found prescription of ‘as required’ intra muscular medication for one patient who was not subject to detention. We have concerns about intramuscular ‘as required’ medication being prescribed for informal patients. This is because it is likely that they would not be consenting to receive the treatment if it was later administered. We consider it best practice for a medical review to be arranged if circumstances arise where intramuscular medication may be required. We discussed this with staff on the day.

We saw on the visit that information about whether or not a welfare attorney or guardian was in place was recorded in Adults with Incapacity Act key information summary sheets. However, copies of powers of attorney and welfare guardians powers were not always recorded in files. We saw that section 47 certificates of incapacity were being completed where patients had been assessed as not able to consent to treatment, with an accompanying treatment plan attached. A local form, NHS Grampian Patient Incapacity Document developed for this purpose had recently been brought into use on Skene and was being rolled out on other wards. We found this to be a helpful and practical document, and we commended this as good practice.

Recommendation 2

Managers should ensure that, where welfare guardians and powers of attorney are identified, a copy of their powers should be listed or clear evidence recorded of attempts made to obtain this information where relatives have not provided it.

Rights and restrictions

There were no undue restrictions to patient freedom of movement and no specified persons on the day. Some patients raised concerns about the difficulty in getting out of doors and this was more difficult in Muick where the ward is upstairs with no easy access to the garden.

We also found that, should patients from another specialty area be moved to the ward due to an appropriate bed being unavailable, it has proved difficult to maintain suitable programmes of care and support due to lack of input from the area of origin.

Recommendation 3

Managers should develop a protocol for the maintenance of programmes of care and support where ward placement is outwith area of specialty.

Activity and occupation

There was no dedicated activity staffing. One nurse per shift has the role of activities link nurse to make sure activities happen but most activity is one to one rather than groups. Staff report that they ‘go with the flow’ rather than scheduling activities and staffing can sometimes be an issue, for example if there are additional demands on staff when they have individuals on constant observation. There was also difficulty in accessing evidence of activities which clearly were taking place. One patient told us that there was a lack of activities suited to her interests.

Physiotherapy input is by referral. However, there is a schedule of exercise classes (shared with other wards) with a class available every weekday – including balance, technogym and chi gong. Occupational therapy input is mainly geared towards

functional assessments aimed at assessing an individual's ability to return home and the level of support and any equipment required.

The physical environment

The wards were clean and bright. There was plentiful space on the wards for walking, sitting and activities. We were pleased to note a piano in the living area on Skene, which we heard being played by a patient, and an attractive fish tank which adds interest. We were advised by a patient that this is the work of a member of staff in her own time. The general condition of the wards, however, was rather tired and in need of upgrading. We heard that Davan ward is closed at present for some work to be carried out. Muick and Skene would also benefit from improvements, especially to furnishings and fittings.

The accommodation, which is mainly in 6-bedded bays, is not ideal, although one patient we spoke with said she preferred being in a bay for company, and had found it lonely in a single room. There is limited access to shower facilities in Skene; the bays have a single en-suite toilet but no shower; there are only two showers for 23 patients on the unit, which staff told us was too few, and has resulted in some patients getting up very early to make sure they can shower.

Appropriate pictorial signage was in place. There was easy access to a dementia friendly and attractive garden for the downstairs ward.

Recommendation 4

Managers should ensure the ward environment is welcoming and fit for purpose, including reviewing the provision of shower facilities on Skene ward.

Any other comments

The atmosphere in both wards was calm and patients seemed relaxed in their environment with many observed to be engaging in activities. Staff interviewed had a good knowledge of the patients in their care, and many of the patients we spoke with were very complimentary about how the staff looked after them.

Summary of recommendations

1. Managers should review of care planning procedures to ensure that all individuals have person-centred care plans that are fully reviewed and evaluated regularly.

2. Managers should ensure that, where welfare guardians and powers of attorney are identified, a copy of their powers should be listed or clear evidence recorded of attempts made to obtain this information where relatives have not provided it.

3. Managers should develop a protocol for the maintenance of programmes of care and support where ward placement is outwith area of specialty.

4. Managers should ensure the ward environment is welcoming and fit for purpose, including reviewing the provision of shower facilities on Skene ward.

Good practice

We heard that the issue of bed socks with gripping soles has led to a significant reduction in incidence of falls especially from patients trying to access the toilet during the night.

The local NHS Grampian form detailing the section 47 Adults with Incapacity certificate developed for this purpose was also commended as good practice.

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 & Participation)

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