Mental Welfare Commission for Scotland

Report on announced visit to: Royal Cornhill Hospital, IPCU Cornhill Road, Aberdeen. AB25 2ZH

Date of visit: 20 September 2016

Where we visited

IPCU ward is situated within the Blair Unit at Royal Cornhill Hospital. IPCU is low secure and contains 11 beds. We last visited this service on a local visit on 3 December 2014 and made the following recommendations; Details of the 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 recommendations and also look at consistency in care plans and recording of 1:1 time with named nurses. This is because of issues identified on the themed visit to IPCU on 1 July 2015. We highlighted in our feedback that there needs to be more consistency in quality and individualisation of care plans whether patients are from mental health or forensic backgrounds.

Who we met with

We met with and/or reviewed the care and treatment of six patients and two carers/relatives/friends.

We spoke with the service manager, the charge nurse and any other clinical staff, including medical staff, at the end of day meeting.

Commission visitors

Douglas Seath, Nursing Officer

Margaret Christie, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The atmosphere in the ward was calm. Patients seemed comfortable in the company of staff and happy to approach them. We saw staff being very proactive in engaging with patients. All interactions we saw were warm, friendly and respectful. We saw patients going off the ward in the company of staff during our visit.

Staff were very knowledgeable about patients when we discussed them. It was apparent that the team provides highly person-centred care.

We were particularly pleased that the individual patients and the carers we spoke to all talked positively about staff within the ward.

We had a number of comments about how staff were supportive and spend time with people individually when this was appropriate and necessary, even though staffing of the ward has been problematic with the number of current nursing vacancies. Meetings between named nurse and patient were also recorded, as recommended on our previous visit.

We noted that risk management plans were often very detailed and personalised, with information about interventions needed. Care plans for all the patients were person centred, contained good information about individual need and were reviewed frequently. The one detail we noted to be missing was the date when the record was initiated. This is crucial, not only in being able to identify when assessments were made but also in clarifying when reviews are required.

We were pleased to see that there is dedicated psychology and occupational therapy input to the ward, and patients confirmed that they had received input from those services where appropriate.

The documentation of the weekly MDT meetings is detailed, with evidence on files of frequent and thorough medical reviews and the minute provides a good record of the progress made and goals set. However, there was a tick list to indicate attendance by discipline, but it did not specify the names of attendees. We suggested that this should be amended to ensure that the names of all attendees are recorded in the records.

There is also a safety brief each day, and this communication system helps prepare for the day, allocate resources and ensures that all relevant information is captured and shared within the Blair Unit.

We met with relatives of two patients during the visit. They made very positive comments about medical and nursing staff delivering a high standard of care, being supportive, and having good relationships with them and their relative. One commented on how much they are consulted, involved and kept informed.

Recommendation 1:

Managers should ensure that all documentation contained in files is properly dated so that chronology of records is clear.

Use of mental health and incapacity legislation

All patients were detained under the Criminal Procedures Act or the Mental Health Act.

Mental Health Act and Adults with Incapacity Act documentation was available where currently active including: detention papers; specified person forms with reasoned opinions; consent to treatment forms; and welfare guardianship powers. We found one consent to treatment form overdue and this has been addressed.

Recommendation 2:

Managers should ensure that all consent to treatment forms are current, and authorise treatments appropriately.

Rights and restrictions

Due to the needs of the patient group, the doors of the wards are locked. Patients who are able to leave can ask staff to do so and may need a nurse escort. The ward has a safe enclosed garden with access from the main corridor of the ward. At the time of the visit, the garden access was restricted due to assessed risk in relation to one patient. However, other patients could access the garden with a nurse presence if required.

One relative complained about the manner of a restraint of an individual undergoing admission to hospital. This was carried out in a way that did not respect the individual's privacy and dignity. We followed this up on the day, and will continue to liaise with local managers on the matter.

Recommendation 3:

Managers should review the accommodation available during the admission process to ensure the privacy and dignity of individuals are protected at all times.

Activity and occupation

Individuals we met were engaged in activities including group activities on the ward and one to one escorted outings. Many of the patients had a good activity programme, which was arranged in consultation with individuals on a weekly basis, giving access to a range of recreational and therapeutic activities to meet their needs.

We heard examples of staff being very creative and flexible in supporting patients to maintain their normal routines and their links into their community. People were clearly benefitting from input from the occupational therapist (OT), OT assistant and nursing staff. However, we did not always find it easy to identify from records when individuals were engaged in activities and when invited but declined to participate.

Recommendation 4:

A record should be available which clearly shows when individuals have been engaged in activities and also when the offer has been made but declined.

The physical environment

The ward, which can take up to 11 patients, was occupied by six patients on the day and was a spacious, bright environment with some new furnishings. Unfortunately, many of the fixtures and fittings on walls had to be removed for reasons of safety, giving the ward a rather bare and unwelcoming appearance. Patients had access to their bedrooms throughout the day.

There is space for activities and access to a secure garden area in which patients have been involved in some gardening. Garden furniture is sparing but there are additional items currently stored safely. Staff have been fundraising to buy equipment and other items for use in activities as there is a need to replace items which are frequently damaged.

Any other comments

One patient had been assessed as no longer requiring the security of IPCU and had been referred to the adult acute admission ward. He had been spending time in the acute ward each day for over one week. However, he unfortunately had to return to IPCU at night as no bed was available in the ward. The patient found this overly restrictive.

Recommendation 5:

Once a patient has been assessed as fit for transfer to lower level of security, managers should effect the transfer in a timely manner.

Summary of recommendations

Recommendation 1:

Managers should ensure that all documentation contained in files is properly dated to so that chronology of records is clear.

Recommendation 2:

Managers should ensure that all consent to treatment forms are current and authorise treatments appropriately.

Recommendation 3:

Managers should review the accommodation available during the admission process to ensure the privacy and dignity of individuals are protected at all times.

Recommendation 4:

A record should be available which clearly shows when individuals have been engaged in activities and also when the offer has been made but declined.

Recommendation 5:

Once a patient has been assessed as fit for transfer to lower level of security, managers should effect the transfer in a timely manner.

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)

1 November 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.

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