Mental Welfare Commission for Scotland

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

Date of visit: 31 May 2016

Where we visited

On 31 May 2016, the Mental Welfare Commission visited Strathbeg and Loirston wards at Royal Cornhill Hospital on a local visit.

Strathbeg ward is a 12-bedded ward providing care for men with progressing dementia and associated symptoms of stress and distress. Loirston ward is a 12 bedded ward providing a corresponding service for female patients.

We last visited this service on 18 August 2015 and made the following recommendations: managers should audit patient care plans for consistency in quality and individualisation and should also monitor recording of one to one reviews by named nurses; managers should review the ward environment and make it more dementia friendly; there should be a review of documentation of all activities.

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, the nurse consultant, ward charge nurses and the occupational therapist.

Commission visitors

Douglas Seath, nursing officer

Ian Cairns, social work officer

Paula John, social work officer

What people told us and what we found

Care, treatment, support and participation

Following our recommendation last year, we reviewed the care planning and risk assessment documentation for the people we visited. Care plans and risk assessments were of a good standard and regularly updated. There were appropriate individual care plans reflecting the needs of the individual person and the content of plans was very detailed and person centred. This was noted particularly in relation to management of stressed and distressed behaviour. The MDT (multi disciplinary team) reviews were also clear and detailed, with all attendees listed. Evaluation of the care plans had been carried out by the named nurse and clearly documented in most files, as recommended in our previous report.

There is good pharmacy input into the units, with regular pharmacy involvement in the MDT reviews. 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.

We found evidence of life histories in many files and staff have also begun work on playlists for life music for each individual.

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.

Use of mental health and incapacity legislation

Mental Health Act paperwork was well organised in files and where people were subject to compulsory measures, medication administered was authorised appropriately by consent to treatment forms (T2) or certificate authorising treatment (T3).

We also 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. Copies of powers of attorneys and welfare guardians were also recorded in files. We saw that s47 certificates of incapacity were being completed where patients had been assessed as not able to consent to treatment, with an accompanying treatment plan attached.

Where patients were subject to covert medication there were appropriate covert medication pathway records available, together with accompanying detailed pharmacist advice about method of administration. We felt this was an example of particularly good practice.

Rights and restrictions

We discussed with managers the issue of Loirston ward being the only single sex accommodation available for non-acute mental health patients. We found that, should vulnerable patients be moved to the ward due to the need for a single sex environment, it has proved difficult to maintain rehabilitation programmes commenced in other settings.

Recommendation 1

Managers should develop a protocol for the maintenance of rehabilitation programmes regardless of ward placement.

Activity and occupation

In both wards, it was clear that it would be difficult to engage several of the patients in group activities because their behaviour is often very agitated and distressed. In such cases, activity provision was often limited to nurses spending one to one time

with the individual person engaging in reminiscence, art, board games or similar pastimes.

Two groups were provided in Loirston on a regular basis: an art group and a sensory group (SONAS). However, the activities room was out of use for a period due to Davan ward being decanted into Loirston whilst the ward is upgraded. The room itself is due to be upgraded to provide a more user friendly environment for a range of activities.

A record of activities taking place is kept in the chronological part of the personal files, as recommended on the last visit.

The physical environment

The wards are 12-bedded with a combination of single room and dormitory accommodation. The reduction in bed numbers provides wards with adequate space for individuals to be in company or on their own, with no sense of overcrowding. The environment in both wards, whilst still being difficult to meet the needs of the patient group due to its age and layout, nevertheless was bright and welcoming.

There were stencils around the corridor walls to create interest and provide decoration. Loirston ward was being used to accommodate patients from Davan ward whilst upgrading in the latter takes place. The wards are not generally dementia friendly, with corridors leading into cul-de-sacs with doors at either end. However, there were signs for toilets and other rooms to help individuals identify their own bed space and the important areas they may wish to use. Access to bedside lockers and wardrobes remains a problem due to dormitories being shared and many patients, due to cognitive impairment, being unaware which one belongs to them. However, the majority of patients have easy access to these. Most bedside areas were personalised. Adjacent to Strathbeg ward is a garden area with its own static car, which patients can sit inside, clean and use in other ways. However, the garden is difficult to access from Loirston ward due to its upstairs location.

Both wards have been earmarked for general upgrade, following on from improvements being made to Davan 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.

It was good to hear about the ward's engagement with community teams and care home liaison nurses during discharge planning.

Summary of recommendations

1. Managers should develop a protocol for the maintenance of rehabilitation programmes regardless of ward placement.

Good practice

We were pleased to see the detailed descriptions provided by the pharmacist on administration of covert medication.

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)

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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