Mental Welfare Commission for Scotland

Report on announced and unannounced visits to:

Fraser and Dunottar Wards, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH

Date of visits: 30 May and 13 June 2017

Where we visited

We visited Fraser Ward on an announced basis on 30 May 2017 and Dunottar ward on an unannounced basis on13 June 2017. The two wards form part of a unit providing rehabilitation for patients of Royal Cornhill Hospital. Fraser ward is a sixteen-bedded mixed-sex slow stream rehabilitation ward. This is a reduction from the twenty beds available on the previous visit. It consists of a mixture of dormitory and single room accommodation with access to both showers and bathrooms. The female patients have a separate single sex sitting area. Dunnottar ward is a twelve-bedded mixed sex inpatient unit for patients with acquired brain injury or neurological disorder resulting in psychiatric or behavioural problems. We last visited this service on 16 March 2013 and made the following recommendations; where a T3 certificate exists, a copy of the entire certificate should be kept with the drug Kardex; there is a need to address the issue of challenges relating to the safe management of patients caused by the mixed-sex nature of Fraser ward.

On the days of this visits we wanted to follow up on the previous recommendations.

Who we met with

We met with and or reviewed the care and treatment of 10 patients.

We spoke with the ward managers and other clinical 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

Individuals in Fraser Ward that we spoke with were complimentary about the treatment provided in the rehabilitation service by both medical and nursing staff and they told us they were treated with respect. Though efforts were made, we were unable to speak with any patients in Dunottar Ward. Those interviewed on the visit did not raise any significant issues about their current care and treatment.

Individuals visited told us they were involved in the formulation of their care plans. The care plans were recovery focussed and were reviewed both in the weekly ward meetings and in regular multi professional review meetings, and there was clear evidence of input from a ward team that included doctors, nurses, occupational therapists and psychologists. A pharmacist also attends ward meetings. There has been difficulty in recruiting permanent medical staff both at consultant and GP level in Fraser ward.

However, the current locum psychiatrist has been in post for some time and the GP post is covered by a Core Trainee Doctor, who manages physical health matters including regular reviews and screening programmes. Documentation of physical health checks was difficult to locate in records.

A risk assessment and safety plan was present and very thorough. There were care plans reviewed recently for, amongst other things; vulnerability, insight, bizarre beliefs, budgeting, physical health, substance misuse, and personal care. However, the evaluation of care plans was inconsistent and present in very few care plans we saw. Nursing one-to-one sessions with service users were taking place according to the nursing staff, but these were difficult to identify in the nursing notes as they are not always recorded.

Specialist services are available with many e.g. occupational therapy, pharmacy, physiotherapy in regular attendance and attending reviews.

Recommendation 1:

Managers should ensure that that 1 to 1 sessions with nursing staff and evaluation of nursing care plans are recorded, and where participation cannot be established, that this is noted.

Use of mental health and incapacity legislation

Most of the people interviewed were detained under the mental health act; they knew about their rights, had been given information about the Mental Health Tribunal, or had been supported by advocacy and accessed a solicitor for Tribunal hearings.

There were s47 Adults with Incapacity (AWI) Act certificates and treatment plans up to date and on file where appropriate. Copies of Welfare Guardianship powers also under the AWI Act were included in most but not all notes reviewed. Consent to treatment forms, T2 and T3 under s240 of the Mental Health Act, were also present and all but one located with the medicine prescription sheet. The missing form was located in the patient file. This was easily rectified.

In Dunottar Ward, we found one patient not subject to detention prescribed an ‘as required’ intramuscular antipsychotic drug. We would not expect a voluntary patient to be prescribed this form of medication, normally given without consent. This had not been given since he had become informal but the prescription had not been adjusted accordingly. Another patient had been prescribed an anti-depressant which had not been authorised on the T3 consent to treatment form. A further patient had been prescribed two anxiolytics to be given orally as required, where only one had been authorised on the T3 consent to treatment form. These matters were raised on the day for immediate remedy.

Recommendation 2:

Managers should implement a robust system for review of consent to treatment forms to ensure that prescriptions comply with the legal requirements of the Mental Health Act.

Rights and restrictions

Fraser ward is permanently open with no restrictions on access to rooms. Patients also have their own keys to lock possessions in wardrobes for safety. Dunottar Ward is locked with notice of how to gain entry or exit.

Patients designated as specified persons under sections 281-286 of the Mental Health Act had up to date RES forms completed and the restrictions appeared appropriate to identified risk.

Activity and occupation

There is an occupational therapist, shared between Fraser and Dunottar Wards, and she provides a variety of activities and assessments on a part-time basis to each. There is also an activities co-ordinator and most patients have a varied programme of available activities both in group and individual settings. One patient from Fraser Ward attends a placement outwith the hospital in preparation for moving on. There is a good throughput with many patients moving on to either hospital, hostel in the community or other residential settings. Some patients have been there a long time and due to their complex needs have proved difficult to rehabilitate from the hospital. However, efforts have clearly been made to initiate rehabilitation programmes and review progress.

Each patient in Fraser Ward, where appropriate, is encouraged to budget and cook for themselves, according to their skills level, with assistance provided if necessary. Those patients we spoke to who engaged in these activities were satisfied with the support offered and the progress they were making towards more independent living.

The physical environment

The wards were in good decorative order, though a little outdated. Some attempts have been made to improve the environment - pictures on walls and some personal possessions in rooms, which are clean and welcoming to visitors. The single sex sitting area in Fraser Ward clearly helps with the safety issue identified on the previous visit. The communal areas appeared to be well provided, though there was no quiet room for individuals to sit in a location apart from the busy shared sitting space. The garden in Fraser Ward is regularly used by patients for gardening and recreational purposes and is well tended with signs of new planting in evidence. Unfortunately, it was somewhat marred in appearance by the evident use by patients to smoke and the litter resulting from cast off cigarette butts spoiled the otherwise pleasant surroundings.

The dormitories were compromised somewhat on provision of privacy though they had fewer beds in each than previously. Single rooms also lacked privacy in having tall internal windows onto the corridor which extended the whole length of the room, though curtains could be drawn right across if necessary.

Recommendation 3:

Arrangements should be made by managers to regularly remove unsightly cigarette butts from the garden entrance doorway.

Recommendation 4:

Managers should review the lack of privacy afforded to patients, especially those in single rooms with windows onto the corridor.

Any other comments

The split between information recorded in hard copy, electronic and separate medical notes makes for potential gaps in information available. Medical reviews were in place for all, and these appeared to be needs led, occurring every 3 -6 months. Good life history or background details were hard to find and would be of great benefit for longer stay patients.

Fraser Ward appears to have diverged from the Scottish patient safety programme recommendation of yellow highlight stickers used to identify frequency of use of as required medication. The benefits to patients of this alternative system could not be easily ascertained.

Recommendation 5:

The ward manager should review the monitoring of as required medication in line with the national patient safety programme best practice guidance.

Summary of recommendations

1. Managers should ensure that that 1 to 1 sessions with nursing staff and evaluation of nursing care plans are recorded, and where participation cannot be established, that this is noted.

2. Managers should implement a robust system for review of consent to treatment forms to ensure that prescriptions comply with the legal requirements of the Mental Health Act.

3. Arrangements should be made by managers to regularly remove unsightly cigarette butts from the garden entrance doorway.

4. Managers should review the lack of privacy afforded to patients, especially those in single rooms with windows onto the corridor

5. The ward manager should review the monitoring of as required medication in line with the national patient safety programme best practice guidance.

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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