Mental Welfare Commission for Scotland

Report on unannounced visit to: Huntly, Drum, and Crathes Wards, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 9 October 2018

Where we visited

We visited the acute admission wards Huntly, Drum and Crathes (adult mental health) in Royal Cornhill Hospital. The three wards accept admissions on a geographical basis. Huntly Ward admits inpatients who are resident in Aberdeen City. They also host Ministry of Defence for Scotland admissions and Shetland admissions. Drum Ward provides inpatient care for a large geographical area across both Aberdeen City and Aberdeenshire. Crathes provides in-patient care for residents in Aberdeenshire. It also caters for Orkney admissions.

On the day of this visit we wanted to follow up on the previous recommendations and also look at the reconfiguration of the wards since our last visit. This is because one of the acute wards had closed on a temporary basis due to difficulty in recruiting nursing and medical staff.

Who we met with

We met with and/or reviewed the care and treatment of 14 patients.

We spoke with the head of hosted services, lead nurse, nurse manager, the charge nurses, and other clinical staff.

Commission visitors

Ian Cairns, Social Work Officer

Douglas Seath, Nursing Officer

Susan Tait, Nursing Officer

Paula John, Social Work Officer

Graham Morgan, Engagement Officer

What people told us and what we found

Care, treatment, support and participation

In all of the wards where we were able to speak to patients we were advised that staff were approachable and would engage with patients in a supportive, compassionate and sensitive way. Patients reported that they felt able to talk to them. Access to medical staff proved to be more difficult.

When reviewing the patients' care plans across the three wards, we found variation in terms of the quality and the completion of the documentation. In all three wards, the care plans varied in terms of the amount of information detailed within them. Some care plans had generic interventions and perfunctory goals, others were very detailed, describing interventions and having a clear recovery focus. In a few care plans, we found reviews of the care goals but again, this varied across all three wards. However, the risk assessments and risk management plans were generally good, and certainly person centered, and multidisciplinary team (MDT) meetings well recorded.

There is an MDT meeting once a week. We were informed that most of the patients attended this meeting, or their views were sought prior to the meeting and received feedback on decisions made afterwards. The clinical discussions that occurred within the meeting were well documented and generated a clear action plan with treatment goals. Patient involvement in their care was evidenced through participation in the ward review and in the compilation of care plans.

There was some evidence of one-to-one sessions between named nurses and patients, but not in all cases and not at regular intervals. Patients said they felt that there was a need for more talking therapy and more one-to-one time. They observed the staff were so busy dealing with a few problematic patients that this put a strain on their time to help others. One patient reported that even when she was first admitted and under increased observation the nurses didn't really speak with her.

Some carers said that staff were so busy that they felt they don't want to ask for help. However, others were very complementary saying they were given information and involved in decisions being made.

However, one patient was full of praise for the nursing staff. She didn't feel afraid to ask anything but the time they had available to respond depended on how busy they were. She understood there were patients who needed more attention. It seemed to her that the staff did not have enough time for the patients who needed more input and this meant that they also did not have enough time for patients who were quieter.

Another patient reported that the hospital was very welcoming of advocacy and kept people well informed of the issues that they faced.

The ward also receives input from clinical pharmacy, and the pharmacist attends the ward on a weekly basis to review medical prescribing and when possible will attend the weekly MDT meeting.

Recommendation 1:

Managers should ensure that care plans focus on individual needs, with clear goals/outcomes, and that there are regular audits of care planning documentation.

Use of mental health and incapacity legislation

There were several issues with regard to medication prescribed for patients subject to detention. A few patients were prescribed medication without due authorisation, either by a consent to treatment form (T2), or by a certificate authorising treatment (T3). Some of the medicines were only to be administered 'if required' but all had been given on at least one occasion. Most of these prescriptions, following audit, had a comment from the pharmacist stating that the medication prescribed did not have appropriate authorisation. However, no subsequent action had been taken by the responsible medical officer (RMO) to seek the authorisation required.

We also had difficulty locating appropriate specified person documentation for one patient who was being restricted. This was discussed with staff on the ward on the day of the visit.

Recommendation 2:

Managers should ensure that recommendations from regular audits of consent to treatment forms are adhered to so that all medication prescribed is legally authorised.

Recommendation 3:

Patients who are subject to detention and have restrictions placed upon them should be made specified persons under the Mental Health (Care & Treatment) (Scotland) Act 2003 (MHA).

Rights and restrictions

There was no available lockable space to keep personal possessions, especially on Huntly Ward which was recently refurbished. Patients had been told that there were no design solutions that would fit with what they want.

A few patients recalled having their rights explained when they were admitted but some were still uncertain of their rights. This was an issue particularly for informal patients being asked to remain in the ward even though they had not been detained. There was also a difficulty encountered by patients unable to get outside, especially when the ward was on an upper floor. One patient mentioned that having written material explaining patients' rights would be helpful.

One voluntary patient, who had been restricted to fixed periods of time to spend off the ward, was unsure if he had been detained under the MHA. He said that he had not received any information to indicate his status. On discussion with staff, we heard that all patients should be given an information pack on admission and informed of their rights if detained under the MHA.

On the day of our visit there were patients on enhanced observations and staff adhered to national guidelines in the use of observations. Within the file we saw evidence of regular reviews and updated risk assessments. This ensured that patients received care in the least restrictive way possible. However, in one ward the practice still appeared to be that the nurse observed the patient in the room from a chair placed by the room door.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

This can be found at https://www.mwcscot.org.uk/rights-in-mind/

Activity and occupation

Some patients reported that there were some things to do in the wards. Others felt that there was not enough going on. There was a notice board with a programme of activities and the occupational therapists explained what activities were available. There was also free Wi-Fi in the wards which patients thought was “fantastic”. Many patients we met also said that were able to go outside every day, sometimes only with a staff escort, and were within reach of two nice parks nearby with cafés. Activities were subject to the ward being adequately staffed.

The physical environment

The environment in the newly refurbished Huntly Ward was a great improvement over the other adult acute admission wards. This improvement had been brought about by the need to try to reduce risk of potential ligature points within the ward. However, the upgrade had extended beyond this to look at improving the layout and furnishings and fittings making the ward a much more pleasant place to be.

The wards are all to be upgraded in turn to this standard and this is very pleasing to see. Huntly Ward stood in sharp contrast to the surroundings in which patients are still being cared for in the remaining wards, “drab and dreary” as described by one of their patients. The upgrade cannot come fast enough though as the furnishings in Crathes and Drum were in very poor state.

Recommendation 4:

All ward environments should be kept to an acceptable standard, especially during the period prior to upgrading when things can deteriorate.

Any other comments

Staffing the wards remains an issue and there is an agreement for use of agency staff up until the end of March 2019. As the nurses are vetted so that they are recruited

from a small pool, this does give some measure of consistency. There are a number of new nursing recruits earmarked to commence from November.

Boarding out remained a problem due to pressure of admissions. Many patients were not being admitted to the correct ward and beds were being filled when patients are home on leave for the night. However, there was a protocol in place now to try to minimise any adverse effects this might have on patient care. Moreover, in the main, this prevented patients having to travel long distances to other psychiatric hospitals in order to find a suitable bed and continuity of their care being disrupted as a result.

There is a lack of psychology input to patients in the wards with no direct input to the ward, and appointments by referral only. The waiting list is so long that patients rarely are seen for assessment before discharge. The ward staff were of the view that clinical psychology was effectively unavailable to in-patients. One patient said that the waiting list was at least six months.

There were fewer delayed discharges than was evident in previous years. Therefore, this was not a contributory factor in the pressure on beds in the adult acute admission wards.

Finally, we felt that due to the number of consultant psychiatrists attached to Drum Ward, having eight ward meetings per week to organise was not a good use of nursing time.

Recommendation 5:

Managers should review the provision of clinical psychology to the acute adult wards to try to reduce time between referral and assessment.

Summary of recommendations

1. Managers should ensure that care plans focus on individual needs, with clear goals/outcomes, and that there are regular audits of care planning documentation.

2. Managers should ensure that recommendations from regular audits of consent to treatment forms are adhered to so that all medication prescribed is legally authorised.

3. Patients who are subject to detention and have restrictions placed upon them should be made specified persons under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA).

4. All ward environments should be kept to an acceptable standard especially during the period prior to upgrading when things can deteriorate.

5. Managers should review the provision of clinical psychology to the acute adult wards to try to reduce time between referral and assessment.

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 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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