

**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Brodie, Corgarff, Drum and Crathes wards, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

**Date of visit:** 11 October 2017

## **Where we visited**

We visited Brodie, Corgarff, Drum and Crathes Wards (adult mental health). All four acute admission wards accept admissions on a geographical basis. Brodie Ward admits in-patients who are resident in Aberdeen City. They also host Ministry of Defence for Scotland admissions and Shetland admissions. Corgarff provides in-patient care for residents in Aberdeen City. They also cater for out-patient ECT (pre and post treatment care). Drum provides in-patient 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, young people (aged 14-17) admissions and also those who are homeless.

We last visited this service on 7 October 2015 and made the recommendations in relation to: the introduction of new care planning documentation; consistency in procedures for multi-disciplinary meetings and patient participation; review of boarding out arrangements; specified persons documentation; improvement in interview room facilities. On the day of this visit we wanted to follow up on the previous recommendations.

Since our last visit, six beds in total have been removed from the four adult acute wards, one each in Crathes/Drum and two each in Brodie/Corgarff. There is a temporary agreement that patients over 60 years should be considered for admission to older adults wards. However, this does not mean a reduction in upper age limit to the adult wards.

## **Who we met with**

We met with and or reviewed the care and treatment of 22 patients.

We spoke with the nurse in charge and other clinical staff on the day.

## **Commission visitors**

Alison Thomson, Executive Director (Nursing)

Margaret Christie, Social Work Practitioner

Douglas Seath, Nursing Practitioner (visit co-ordinator)

Ian Cairns, Social Work Practitioner

## **What people told us and what we found**

### **Care, treatment, support and participation**

New care plan documentation is now in place, and overall care plans were detailed and person-centred. Each patient had a risk assessment and risk management plan management plan arising from this. In addition, there was a care and recovery plan for nursing interventions with reviews being carried out. One file, where the adult had

been in hospital for several weeks, had little information. This matter was raised with the senior charge nurse (SCN) in the morning, and the named nurse immediately began completing care plans in the afternoon. The other files in the main had detailed and individualised care plans which were clearly reviewed and re-written where necessary. Also, there was evidence that patients either signed care plans, or it is recorded that they weren't willing or weren't able to sign them or participate in discussions regarding their plans.

We observed good records of multi-disciplinary team meetings with a note of those in attendance.

Two patients we met with wanted to let us know that the nurses were too busy, particularly spending long periods doing paperwork, but also attending to very distressed patients, and this left little time for them to engage with other patients (although interactions which did take place were reportedly polite and respectful). This was reported to disrupt the ability of nurses to spend time with patients on a one-to-one basis, and this was also what we noted in the records. We did observe nursing staff in duty rooms for significant periods during our visit.

### **Recommendation 1:**

Managers should ensure that named nurses are able to engage with, and document, one-to-one time with their patients and that this is not prevented by administration duties.

### **Use of mental health and incapacity legislation**

One compulsorily detained patient in Corgarff had a T2 (consent to treatment) form in place when clearly not consenting to the medication. Therefore, this person should have been subject to a T3 (certificate authorising treatment) with a second opinion doctor report. This was raised for immediate attention with staff to follow up with the responsible medical officer (RMO).

Another patient should have had a consent to treatment form in place almost a month previously. The senior charge nurse (SCN) was informed and agreed to take this up urgently with the RMO. Additionally, we observed some other issues regarding authorisation of medication which needed rectification. These were also passed to staff to be addressed by the RMO. We noted that there didn't seem to be any audits of medication by pharmacy, and nurses appeared not to be monitoring if T2 or T3 forms were necessary or in place when dispensing medication.

There is also a standard s47 paperwork document which included treatment plans.

There were no issues with specified person documentation.

## **Recommendation 2:**

Managers should introduce an audit tool to monitor consent to treatment documentation in order to ensure that all treatments are legally authorised.

## **Rights and restrictions**

There was good information visible in the ward with information about activities and a board called 'Carers Corner', with information for carers, including information about support groups.

Crathes Ward has piloted a changed approach to decisions about observation levels in line with the new draft national guidance on patient engagement under development. Someone may be on enhanced support, but observation level can change during the day with one-to-one support provided at specific times when someone is more stressed/distressed. This links with hourly observation checks which have a traffic light system, and if someone is rated amber or red then they will be offered one-to-one support or an immediate decision is taken about implementing one-to-one support. The SCN said the new system is much more flexible and responsive, and that with the hourly charts they have been able to see patterns with specific patients, who have for example been more stressed at specific times of the day. Often this will be discussed with the doctor and, for example, it may be decided that it would be more beneficial for a patient if the times for administering prescribed medication were changed accordingly.

In terms of the Commission's publication 'Rights in Mind', there was some acknowledgement of the Commission's guidance on Corgarff ward and we were informed the service has just engaged with the national evaluation programme to test this with their community mental health team and affiliated in-patient team in Crathes ward.

## **Activity and occupation**

On the day, there was little evidence of activities taking place, but some of activities were recorded in notes along with nursing one-to-one sessions. Options on the wards were provided by occupational therapy staff and some patients reported attending these including artwork, walking group, DIY and breakfast club.

## **The physical environment**

The interview room in Corgarff Ward has been renovated since the last local visit.

Smoking remains a big issue with patients continuing to smoke in the garden which is against hospital policy. This also led to evidence of a strong smell of smoke in some parts of the wards.

Environmentally, the wards were observed to be a bit dated in decoration and furnishings, with limited privacy in dormitories. A small therapeutic room was available in some of the wards. The dining and sitting rooms were communal, and also gave little privacy. The side rooms had large sliding doors with glass filled panels which can be covered by a curtain. These rooms look onto the central courtyard /garden area which felt quite exposed.

We heard that wards are to be decanted one by one and completely refurbished as a result of recent review of ligature risk. The Health and Safety Executive report, following an in-patient suicide, contained a requirement that NHS Grampian addresses ligature point issues across the hospital, although with a three year timescale.

### **Any other comments**

We were informed about ongoing staffing shortages in wards and consequent high use of bank nurses and overtime. Also, due to pressure of admissions, the boarding out of patients continues and is reportedly getting worse. Boarding out occurs when there is no available bed for a new admission in the ward. This leads either to a patient already in the ward having to board in another ward, or to the new admission being admitted to a different ward temporarily.

Over the last few months, wards have been assessed as at high risk level. This means that staff are less able to carry out activities. Though there are activity workers Monday to Friday there is only one activity nurse for the four wards. Staff retention was still an issue and the majority of nurses were doing a 12-hour shift.

Staff in one ward reported a difficulty in getting quick access to intensive psychiatric care unit beds as the ward has a large number of female forensic patients. There is no other low secure unit in Grampian to admit female patients.

There were two Orkney patients who were delayed discharges, and staff said they have difficulties in general with discharge planning to Orkney due to a lack of formal agreement or contract. We are following up these issues with relevant staff.

The service was reported to be looking at mental health redesign at present, and considering a combination of a 72-hour acute admission ward with three ongoing treatment wards. We look forward to having updates on the progress of this proposal.

### **Recommendation 3:**

Following our visit to the service in 2015, managers agreed to review the boarding out policy/protocol, in order to minimise the need for patients to experience lack of continuity in their care and treatment. As the issue of boarding out of patients remains significant, the Commission request a copy of the outcome of the review and its impact on this issue.

## **Summary of recommendations**

1. Managers should ensure that named nurses are able to engage with, and document, one-to-one time with their patients and that this is not prevented by administration duties.
2. Managers should introduce an audit tool to monitor consent to treatment documentation in order to ensure that all treatments are legally authorised.
3. Following our visit to the service in 2015, managers agreed to review the boarding out policy/protocol, in order to minimise the need for patients to experience lack of continuity in their care and treatment. As the issue of boarding out of patients remains significant, the Commission request a copy of the outcome of the review and its impact on this issue.

## **Good practice**

Documentation recorded that right to advocacy was explained to patients, and we noted Section 260 provision of information mental health act checklists in files.

## **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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