



Mental Welfare Commission for Scotland

Report on announced visit to: Davan, Muick and Skene wards,
Royal Cornhill Hospital, Cornhill Road, ABERDEEN, AB25 2ZH

Date of visit: 31 August 2017

Where we visited

Davan is a 16-bedded dementia assessment ward. Muick is a 24-bedded mixed-sex functional assessment ward for Aberdeen city, Orkney and Shetland. Skene is a 23-bedded functional ward for older adults. We last visited this service on 22 June 2016 and 28 February 2017 and made recommendations in the following areas: involvement of carers; safe storage of possessions; person-centred care plans; record of proxy powers; care of patients from other wards; and environmental issues. On the day of this visit we wanted to follow up on the previous recommendations.

We received a response to the recommendations from the service identifying training needs and audit in relation to: care plans and proxy powers; liaison protocol with host ward; upgrade funding application for environmental improvements.

Who we met with

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

We spoke with the service manager, the charge nurses and other nursing staff.

Commission visitors

Douglas Seath, Nursing Officer

Margaret Christie, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Where we were able to have meaningful conversations with patients, they were positive about care and treatment provided in the wards. We observed supportive interaction between nursing staff and individuals and there was a calm, caring atmosphere.

Risk assessment and management plans were in place and reviewed. Care and recovery plans were detailed and personalised, identifying the nature of individual patients' needs and the effectiveness of interventions was being regularly reviewed and evaluated, though the recording of reviews of care plans in continuation notes made it harder to locate these.

We saw 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms in files with evidence of the involvement of guardians or attorneys in any advance decision not to give CPR.

Basic life history information seems to be collected where possible and to be available in files. The multidisciplinary team review meetings were also well recorded in files.

Patients also had access to allied health professionals e.g. psychology and occupational therapy where assessed as appropriate.

Use of mental health and incapacity legislation

Where individuals were subject to the Mental Health Act (MHA) paperwork was well maintained. Consent to treatment certificate (T2) or certificate authorising treatment (T3) forms were in place to authorise treatment. One patient, who is now an informal patient but was very recently detained under the MHA, was still prescribed intramuscular (IM) medication for agitation. The individual had not received any IM medication since the detention was revoked and it was agreed on the day that this prescription would be discontinued.

We noted that the s47 certificate paperwork and treatment plans were in place where appropriate.

We had previously recommended that the hospital should ask any attorney or guardian for a copy of orders granted and were pleased to see that copies of relevant powers of attorney or guardianship orders were on file.

It was noted that finding the mental health act status of individual patients was not easy to ascertain. The status was recorded on admission but the form has no space for an update nor record of other aspects of compulsory care e.g. specified person, suspension of detention.

Recommendation 1:

Managers should consider use of an index page for mental health act information including current detention status and a record of all other forms in use.

Rights and restrictions

The wards are located on both the ground floor and first floor of the main hospital building. Patients placed in upstairs wards have difficulty accessing the external garden but are able to do so when nurses or relatives are available to escort and the garden is well maintained and a pleasant environment in which to sit.

Translation services were readily available for those whose first language is not English and had been taken up on a regular basis.

Activity and occupation

We noted patients engaged in a range of activities in the wards during our visit. The activities provided show that nurses were bringing a great deal of enthusiasm and creativity to their work, with activities designed to meet the interests and abilities of patients. Patient likes and dislikes in this area were clearly documented to assist with programme development. Activities included: quiz games; puzzles; knitting; artwork and gym.

We saw several good examples of activities which were specifically arranged to build on the interests of individual patients and some of the skills they had retained from things they liked doing in the past. We also saw very good examples of individual patients, who now have difficulty participating in group activities, being encouraged to participate in one to one activities, again designed around interests identified from the person's life history. The records also documented where activities were offered but

The physical environment

There was dementia-friendly signage on most of the doors and other changes have been made to reflect recommendations by the Stirling Dementia Services Development Centre.

Most of the shower rooms have been upgraded with only one remaining to be completed.

One patient described feeling very hot during the day but so cold at night that she had to request extra blankets.

Recommendation 2:

Managers should monitor ward temperature to ensure it is within acceptable limits throughout the 24-hour period.

Summary of recommendations

1. Managers should consider use of an index page for mental health act information including current detention status and a record of all other forms in use.
2. Managers should monitor ward temperature to ensure it is within acceptable limits throughout the 24 hour period.

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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