

**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Royal Cornhill Hospital, Davan  
ward, Cornhill Road, Aberdeen AB25 2ZH

**Date of visit:** 28 February 2017

## **Where we visited**

Davan ward is a 16-bedded specialist dementia assessment unit on the ground floor of Royal Cornhill Hospital, Aberdeen. It comprises two male dormitories, one female dormitory, and five single rooms. The ward also has access to a large conservatory and enclosed garden. We last visited this service on 9 July 2015 and made the following recommendations: there needs to be an audit of the frequency of activities; patients should have the option to attend reviews; Mental Health Act documentation should be easily located in patient files; and powers of any proxy should be recorded and staff made aware of these.

On the day of this visit we wanted to follow up on the previous recommendations and look at how the recent refurbishment has improved the environment.

## **Who we met with**

We met with and/or reviewed the care and treatment of six patients and spoke with four relatives.

We spoke with the service manager, the charge nurse and other clinical 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**

We saw good care plans in the file reviews we undertook on the day. Plans were recovery focussed, identifying needs and actions, and there was evidence of evaluation of care plans. The multidisciplinary team reviews we looked at were well recorded, had good descriptions of progress being made in relation to plans of care, and included a record of who had participated in the meetings.

Where we were able to have meaningful conversations with patients, they were positive about care and treatment provided in the ward. The four relatives we spoke to were also positive about the care and treatment provided by nurses and medical staff. They felt communication with the ward teams was good, that they always felt welcome in the ward, and their observations were that staff were helpful, supportive and very understanding in their interactions with patients.

Life history information was recorded in the files we reviewed, with 'Getting to know me' booklets, completed with help from relatives, in the files.

Carers are invited to monthly information sessions on a variety of topics and can feed back views or concerns at regular meetings with the charge nurse. However, some relatives indicated there is a difficulty in getting to meet consultant psychiatrists, one saying they have only met once in eight months and only at their request. One doctor is regularly available to discuss issues, but usually by telephone. Relatives stated they would rather meet face to face.

We were pleased to see that a covert medication pathway, taken from the Commission's good practice guidance, was being used appropriately.

### **Recommendation 1:**

Managers should find ways to involve relatives more in reviews of patient care by medical staff throughout the period of admission.

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

Mental Health (Care & Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000 ('AWI Act') documentation was located in files, which were clearly indexed and easy to navigate. Where individuals were assessed as lacking capacity to consent to their treatment, and were being treated under Part 5 of the AWI Act, s47 certificates authorising treatment were on file, with appropriate treatment plans.

Where individuals were subject to the Mental Health Act, paperwork was well maintained. 'Consent to treatment certificate (T2)' or 'certificate authorising treatment (T3)' forms were in place to authorise treatment in most cases. One individual had been prescribed an anxiolytic as required, which was not authorised on the T3 form. This is being followed up with the individual doctor.

Where we saw 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms in files, there was evidence of the involvement of guardians or attorneys in any advance decision not to give CPR.

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. Where there is a proxy, the ward use the AWI Act checklist provided by the Commission to record relevant details for ease of access.

### **Rights and restrictions**

As the individuals in the ward all have a diagnosis of dementia, the external fire door to the ward is locked to maintain safety and to prevent patients leaving the ward unnoticed. All staff have a key should the door need to be unlocked in an emergency. The external doors are disguised with murals and this distracts individuals from the area and diverts them to the sitting room nearby. Locked door policies are in place

and are reviewed regularly and information about this is contained within information booklets given to relatives and patients on admission. Information about the locked door policy is displayed at the door of the ward.

### **Activity and occupation**

We noted patients engaged in a range of activities during our visit. 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 designed around interests identified from the person's life history. There was also good input from physiotherapy and from occupational therapy. The physiotherapist runs strength and balance groups, makes use of the technogym and also gives individual input where indicated.

One relative was concerned that there was no displayed programme of activities available on the ward. Therefore, there was no indication for relatives about activities which were being offered. However, we were informed that the decision about which activities are pursued rested with nursing staff on duty and the willingness or capacity of patients to participate. There is a record in patient files of staff engaging patients in activities and a record of patients being invited to participate in activities but unwilling to do so.

### **The physical environment**

Recent refurbishment work in the ward has helped create an environment which is much more dementia friendly. The flooring is now non-slip, matt vinyl and consistent throughout, so there are no awkward transitions when entering or exiting rooms. The sitting rooms are being fitted with historical furnishings, with designs in keeping with current patients' past experiences. Visitors also heard of plans from a very enthusiastic staff group to further develop the environment, including the garden area, in a dementia friendly way.

There were issues around the safe storage of patients' belongings and these have been exacerbated by a risk assessment deeming the available wardrobes as unsuitable for placement in individual bedrooms. It is important for patients with dementia to have familiar items and possessions around them when in unfamiliar situations. Therefore, this is an unsatisfactory and potentially disorientating situation for all patients in the ward.

Although the reduction in beds in recent years has helped, the use of dormitories in a dementia assessment ward is not ideal. However, opportunities to change this are limited by the design of the building.

**Recommendation 2:**

Managers should find a solution to the safe storage of personal possessions so that patients can have these available in their rooms.

**Summary of recommendations**

1. Managers should find ways to involve relatives more in reviews of patient care by medical staff throughout the period of admission.
2. Managers should find a solution to the safe storage of personal possessions so that patients can have these available in their rooms.

**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.

**Contact details:**

**The Mental Welfare Commission for Scotland**  
**Thistle House**  
**91 Haymarket Terrace**  
**Edinburgh**  
**EH12 5HE**

telephone: 0131 313 8777

e-mail: [enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)

website: [www.mwscot.org.uk](http://www.mwscot.org.uk)

