

**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:**

Strathbeg and Loirston Wards, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH

**Date of visit:** 13 June 2017

## **Where we visited**

On 13 June 2017 the Mental Welfare Commission visited Strathbeg and Loirston Wards at Royal Cornhill Hospital on an unannounced local visit.

Strathbeg Ward is a 12 bed ward providing care for men with progressing dementia, and associated symptoms of stress and distress. Loirston Ward is a 12 bed ward providing a corresponding service for female patients.

We last visited this service on 31 May 2016, when we made one recommendation about maintaining a focus on rehabilitation activities.

On the day of this visit we wanted to look generally at the provision of care and treatment in the two wards.

## **Who we met with**

We met with and/or reviewed the care and treatment of eight patients and we met with two relatives.

We spoke with staff nurses, the senior charge nurse (Strathbeg), the nurse manager for the units, and the overall service manager. We also spoke with one of the consultant psychiatrists who is covering the wards, with one of the activity coordinators and with the discharge coordinator.

## **Commission visitors**

Ian Cairns, Social Work Officer and visit coordinator

Claire Lamza, Nursing Officer

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

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

Integrated files are now in place in both Strathbeg and Loirston wards, with medical and nursing staff making entries in one joint file, and with input from other health professionals also located in the same folder. Files are well organised and maintained, with a clear index card at the front of the file and the corresponding information easily located in each individual patient file.

Care plans in both wards were of a very good standard. The format of the care plans has a clear structure, identifying care goals, any barriers to achieving goals, and actions or interventions which nursing staff should be undertaking. Plans are detailed and person centred, and in reading the care plans there is a clear connection between specific goals and interventions and how the individual is achieving this on a day-to-day basis. For example, where care goal one is set out, there is a corresponding daily review that notes how the patient's response is in relation to care goal one; this meant

that we could clearly see and evaluate how the patient responds to their care and treatment. This happens for each defined care goal that is specific to each person's needs. Plans are also reviewed regularly, and where reviews identify the need for a plan to be updated, the update is identifiable in the plan

Each care plan had a clear focus on recovery; the goals were written to incorporate this, including those goals relating to stress and distress. The individual's plans which detail how staff will provide support when a patient is agitated or distressed, were particularly good. In all the files reviewed there was a stress/distress plan, which had very clear information about the individual person, about the particular way they might demonstrate that they were stressed or distressed, and about the specific approaches which could help to reduce agitation. Where appropriate, the stress/distress care plans were accompanied by specialist assessments and the guidance prepared by occupational therapists or by the clinical psychology service.

In Loirston, where applicable, the care plans have a 'getting to know me' document that provides essential life history information. For some of the patients, this leads on to a more comprehensive Life Story, co-ordinated by the named nurse, who encourages the family to be actively involved. This is then useful when there is a transfer of care to another inpatient service.

### **Recommendation 1:**

Managers should ensure that where applicable, all patients who would benefit from having a completed Life Story should have one completed within six months of admission.

The regular multidisciplinary team (MDT) reviews were also well recorded, with information about people who attended these reviews, with some summative information about any changes in care and treatment needs since the previous meeting, and with clear action points agreed.

The relatives that we spoke to on our visit were very happy with the care that people were receiving. They explained to us that they appreciated being fully involved, and told us that they were given both verbal and written information about care decisions, and invited to contribute their views. They thought that the clinical staff were proactive and considerate of quality of life issues.

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

Mental Health Act paperwork in files was well organised, and as on the last visit where people were subject to compulsory measures medication administered was authorised appropriately by T3 certificates, the certificates completed by a designated medical practitioner which authorise treatment.

A significant number of patients in Strathbeg and Loirston had previously granted powers of attorney, and this was well recorded in files, with copies of the powers also

seen in files. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 of the Adults with Incapacity Act must be completed by a doctor. In all the files reviewed in both wards, s47 certificates were in place where appropriate. These certificates have been incorporated into a more general document with information about the individual patient's capacity, and about any welfare proxy in place. Every s47 certificate had very well completed treatment plans with information about conditions for which treatments were being prescribed.

In the relevant files that we reviewed, there were 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms in place with information about relatives who were consulted before this decision was taken.

### **Rights and restrictions**

From the files reviewed in Strathbeg and Loirston, it was clear that compulsory measures are put in place when this is felt to be appropriate and necessary. The door of both wards was locked on the day of our visit, but information about the locked door policy was clearly displayed, and it was also clear in file reviews that the door was locked because of quite specific clinical needs.

The use of covert medication pathways were noted in some of the files we reviewed. The information in each patient's pathway is comprehensive and meets the legal requirements of the Act. A copy of each pathway is in the care plan and in the medication sheets.

### **Activity and occupation**

In Strathbeg ward there is one activity coordinator in place, with one part-time post currently vacant. Many patients have limited concentration for focussing on activities, but patients were engaging in artwork and in board games during the visit. A regular art group is run in Strathbeg ward by Grampian Arts Trust, and the Therapet Service also visits the ward regularly. The activity coordinator also explained how they organise social events regularly, which relatives are encouraged to attend, as well as providing activities for patients in the ward.

In Loirston ward, there is evidence of active involvement of the occupational therapist, physiotherapy, psychology, the nursing team and staff from the independent sector all contributing to the activity and occupation of the women's needs. There are formal assessments, such as the 'Pool Activity Level (PAL)' and the 'Activity Prescription' that identify the specific interests of those women whose care we reviewed. There is clear evidence that the ward provides a range of activities; opportunities for the women to attend groups, dancing, games and music are frequently noted in care plans, as are outings. Of the care plans that we reviewed, the notes indicate that women access the garden for Strathbeg, go out shopping, go home with their families and visit local amenities such as the park for ice cream and local gardens.

## **The physical environment**

The wards are 12-bed wards with a combination of single rooms and dormitory accommodation.

In Strathbeg ward, work has been done involving relatives to look at the physical environment, and how this can be made more dementia friendly. This has resulted in information and signage displayed in the ward being reduced and simplified to make the environment less cluttered.

In Loirston, there is also décor that improves the general environment. For example, the day room with its woodland theme, the door exiting the ward that looks like a bookcase, and the areas around each patient's bed where there is wall art and a space for personal information. Developing this further will improve the physical environment.

There is an enclosed garden area accessible from Strathbeg Ward, which provides an opportunity for patients to access fresh air. Some work has been identified as needing to be done in the garden area. This involves dealing with some trip hazards, and also increasing the height of raised beds which are in place in the garden, so that patients can help with planting the raised beds.

Managers should ensure that the environmental changes in Loirston continue to personalise the ward and that necessary work in Strathbeg is completed to allow more use to be made of the garden space.

## **Summary of recommendations**

1. Managers should ensure that where applicable, all patients who would benefit from having a completed Life Story should have one completed within six months of admission.

## **Good practice**

We found the care plans had a focus on recovery, and the stress and distress care plans were comprehensive in describing the care needs in an individualised, person centred way. It was useful to be able to understand and review how the care that is being delivered is making a difference with each patient as the goals are linked to the daily notes.

Strathbeg ward is one of four demonstrator sites in Scotland that are working with Healthcare Improvement Scotland (HIS) as part of a specialist dementia unit improvement programme. We heard on this visit about work that has already been undertaken, with peer reviews of interactions between staff and patients, and with video walk rounds with carers to look at any changes they would like to see in the physical environment in the ward. Changes to the physical environment in the ward and to the administration of medication have already been made in the ward, and there will be more interviews with family members and carers to identify other changes which

can be taken forward. It was clear on the visit that the ward manager in Strathbeg is very enthusiastic about the learning process which is being developed as a demonstrator site. It was also clear from speaking to staff on the day that they are positive about this process, and can see real benefits in the way the provision of care and treatment in the ward is developing. There were also several specific examples of good practice which we saw on the visit.

- Strathbeg ward has introduced a ceiling of treatment approach within the ward. This involves clearly documenting how care and treatment is to be provided in the ward when a patient's condition is deteriorating, and having open discussions with family members about this issue, about limits to healthcare interventions, and about how decisions should be made about why it might not be appropriate to transfer patients to a general hospital for physical treatment.

- Fall review documentation

New documentation is used in the ward, to be completed when any patient has had a fall. The form is completed by the nurse or doctor who first responds to a fall, there is a medical review by the psychiatrist, and then there is a rapid root cause analysis. The form seems well designed, to encourage quick identification of preventive action or steps which could be taken to reduce fall risks.

- Family Communication

Part of the demonstrator site work has involved developing communication links between staff in the ward and family members. Each patient file now has a communication care plan which focusses on communication between family members and ward staff. It is also clearly expected that there are regular meetings between named nurses and relatives, with specific forms in place to record discussions at these meetings, and with records of these meetings easily located in individual patient 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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