



Mental Welfare Commission for Scotland

Report on unannounced visit to: Dunottar Ward, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH

Date of visit: 11 June 2019

Where we visited

Dunnottar Ward is a 12-bedded mixed-sex inpatient unit for patients with acquired brain injury or neurological disorder resulting in psychiatric or behavioural problems. The ward has a mixture of single rooms and dormitory accommodation, but has been arranged so that each patient has a room to themselves. We last visited this service on 13 June 2017 and made the following recommendation: managers should implement a robust system for review of consent to treatment forms to ensure that prescriptions comply with the legal requirements of the Mental Health (Care & Treatment) (Scotland) Act 2003.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendation, and to ensure that the care, treatment and facilities are meeting patients' needs.

Who we met with

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

We spoke with the senior charge nurse and other nursing staff.

Commission visitors

Douglas Seath, Nursing Officer

Tracey Ferguson, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with were very positive about the care and treatment provided by the nursing staff, and felt that they were approachable and respectful. We found that staff knew the patients well and patients we met with were complimentary of staff support. We observed positive interactions between staff and patients during the time we spent on the ward. The staff told us of the sense of cohesive teamwork they feel they have, which they believe contributes to the positive care and treatment received by the patients.

There is a mixed group of patients in the ward. Many of the patients have been in hospital for a considerable period of time and the longstanding nature of their illness means that their volition to become involved in social, recreational and therapeutic activities can be limited. However, we were able to see positive interventions from nursing, occupational therapy and physiotherapy staff.

Due to the nature of behavioural issues that patients present with, staff have been receiving training in RAID approach. RAID[®] (Reinforce Appropriate, Implode Disruptive) is a leading positive psychology approach for tackling challenging behaviour when it occurs, but also to prevent it by tackling it at source.

Many of the patients have complex physical health and mobility problems in addition to their mental health issues. There is one consultant psychiatrist who covers the ward with assistance in physical health matters from a GP. All patients have an annual physical health check. The ward has regular input from psychology and occupational therapy, both in group work and on an individual basis. There is also input from the pharmacist on a regular basis.

Care plans were person-centred with an emphasis on recovery; detail focused on physical health, mental health and social needs. There was good information in relation to individual background histories with a personal summary on each record. Risk assessment and management plans were completed and updated as necessary.

We saw evidence of one to one meetings between patients and their named nurse recorded in the chronological notes, along with a record of weekly multidisciplinary meetings. However, there was a lack of evidence of regular evaluation of care plans, with dates of review recorded but no substantive information on the progress made in relation to care plan goals.

There was one patient who was deemed to be delayed discharge but a placement has been identified for transfer in the near future.

Recommendation 1:

Managers should ensure that care plan evaluation and reviews are meaningful, and include the effectiveness of interventions and reflect any changes in the individual's care needs.

Use of mental health and incapacity legislation

There was evidence of progress in appropriate authorisation for treatment which was a recommendation of the previous report. Within patient files we saw Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') section 47 certificates accompanied by treatment plans relevant to the individual. Consent to treatment certificates (T2) and certificate authorising treatments (T3) were also in place where required, with covert medication pathways also in place where necessary. There were also appropriate section 48 (AWI Act) certificates for patients receiving particular medications.

Many of the patients had welfare guardianship in place and we found that staff had knowledge of the AWI Act and were including proxy decision makers in discussions, when relevant. It was noted that where details of changes had occurred, these were not always updated on the record.

Rights and restrictions

It was evident that supported decision-making was promoted and encouraged and, where appropriate, advocacy services were also involved in assisting with the patient's involvement in discussing their care and treatment.

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/law-and-rights/rights-mind>

Activity and occupation

During the visit we saw individuals engaging in therapeutic and social activity. It was good to see that individuals have a note of their scheduled activity for the day from occupational therapy and physiotherapy. We could also see in notes that nursing staff were recording participation of individuals in social/recreational activity.

Activities include jigsaws, singing, head and hand massage, a newspaper discussion group, art, therapy and trips out for coffee, lunch and to places of interest. The activity nurse, shared with another ward, assists with these activities on a part-time basis.

Patients told us that activities have improved and that there is a good emphasis on community-based events.

The physical environment

Overall we found the environment to be clean, bright and well-maintained, though in need of upgrading. Corridors were clear of clutter allowing wheelchair access with ease. We were also told that the ward will be relocated in the near future due to an ongoing refurbishment programme and that it will continue to be provided on a ground floor ward with ease of access to outside space.

Patients in Dunottar Ward currently have access to an enclosed garden and we saw that patients have been involved in planting and generally improving the outdoor area.

Any other comments

Patients we met with were complimentary of staff support and interaction. We also found staff to be welcoming and helpful throughout our visit.

It was good to hear that there is an emphasis on staff training, especially around the approach to behavioural issues and the use of the AWI Act, and that the service is ensuring documentation reflects Scottish legislation as appropriate.

Summary of recommendations

1. Managers should ensure that care plan evaluation and reviews are meaningful, and include the effectiveness of interventions and reflect any changes in the individual's care needs.

Service response to recommendations

The Commission requires a response to this recommendation 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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