Mental Welfare Commission for Scotland

Report on announced visit to: Ashcroft Ward, Bennachie View Care Village, Inverurie, AB51 5DF

Date of visit: 11 February 2020

Where we visited

Ashcroft ward is a 10-bedded specialist dementia assessment ward set within the Bennachie View Care Home and Village on the outskirts of Inverurie. Bennachie View comprises a large care home, the ward, and a number of small bungalows in a village-type setting. The service was opened in 2016 as part of a new development by Aberdeenshire Integrated Health and Social Care Partnership. There were seven patients in the ward at the time of this visit.

We last visited this service on 19 February 2018 and made recommendations in relation to nursing care plans, incapacity legislation requirements, and the physical environment.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendations.

Who we met with

We met with and/or reviewed the care and treatment of six patients and one relative.

We spoke with the senior charge, nurse (SCN), location manager, nursing staff and health care support workers.

Commission visitors

Tracey Ferguson Social Work Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We were not able to have detailed conversations with all the patients in the ward, because of the progression of their illness. However, we were to meet and introduce ourselves to a number of patients who told us that they were happy on the ward, and they appeared settled and relaxed in the environment.

We observed supportive interactions between nursing staff and patients in the ward during our visit. The relative we met with also gave positive feedback about the care and treatment provided

We saw detailed nursing assessment documentation in patient files which gave a good account of the patient's background and current circumstances. Life history information was recorded in the files we reviewed, with 'Getting to Know Me' booklets, completed with help from relatives.

The ward has a full time occupational therapist (OT) and a referral system is in place should a patient require assessment and/or treatment from another allied health professional (AHP). We were told that the AHPs are based within the Bennachie View Care Village, and that patient referrals are acted on right away.

Managers told us that the multidisciplinary team (MDT) meetings are held weekly where the range of professionals involved in the patient's care attends. The GP, who visits the ward twice a week, also attends these meetings to discuss patients' physical health care needs.

We saw detailed recording of MDT minutes in the patient file with clear actions and outcomes being recorded; however detail was variable across the files. The level of detail was lacking particularly around discharge planning. It was not always clear as to who attended the MDT or if the patient participated in the meeting. We saw two records of the MDT meeting, one which was stored within the patient nursing file, and another in the medical notes. We felt this was confusing and discussed this further with the managers on the day. We saw in the format of the nursing file that there was good documentation that covered patient's rights, however this was not always completed. We discussed this further with the managers on the day as to how this form can be used to better effective to ensure patients' rights continue to be discussed and reviewed.

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

We wanted to follow up on the recommendation on our last visit about care plans. We saw care plans that were detailed, holistic and regularly reviewed; however, the standard was variable across patient files. We saw where some progress has been made however some care plans lacked in detail about the interventions required to meet the identified need. We were able to see that care plans were being reviewed regular and that one-to-one meetings

with nursing staff (as per care plans) were being carried out; however there was no summative evaluation being recorded in some files. We saw some care plans in place where the identified need was for mental health assessment; however, from viewing some care plans it was difficult to know if there was an outcome of this assessment as this was same care plan following patient being in ward for six months.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

The newly-appointed SCN told us she has identified areas for development including a review of patients' documentation. Where it had been identified that a patient was fit for discharge, we saw from file reviews that active planning was in place.

Recommendation 1:

Managers should ensure that clear actions are recorded as part of the MDT along with discharge planning activity for individuals whose discharge has been delayed, to ensure this remains focussed and within agreed timescales.

Recommendation 2:

Managers should ensure that nursing care plans are person-centred, outlining interventions to meet the identified needs and include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out, and any required changes to meet care goals.

Use of mental health and incapacity legislation

On the day of our visit paperwork under the Mental Health Act (Care and Treatment) (Scotland) 2003 ('the Mental Health Act') was easy to access within patients' records.

Part 16 (s235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. The authorising treatment form (T3) was in order, and we discussed with managers that a copy of the form should be kept beside the drug prescription sheet.

For individuals who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') we saw a copy of the document in the patient's file; where we found no copy, we brought this to the manager's attention.

We wanted to follow up on the recommendation on our last visit about the completion of s47 certificates. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate is completed by a doctor under section 47 of the AWI Act.

We noted that s47 certificates were in place, accompanied by treatment plans relevant to the patient and that any proxy decision maker had been consulted.

The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf).

This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. 'Do not attempt CPR' forms were completed in some files with evidence of discussion with nearest relative or proxy as appropriate, apart from one file. We brought this to the manager's attention on the day.

Rights and restrictions

There is a secure entry to the ward accessed by a doorbell entry system. There is a locked door policy in place and was on display. We discussed this with staff and gave advice on an individual case where we were not clear that the patient was consenting to the admission. Alarm sensors in rooms were used to alert staff when patients at risk of falls required assistance to get up to the toilet at night. Following on from a recommendation at our last visit, we were told that the performance of the alarms was monitored and there were no issues with the alarms on the day of the visit.

Activity and occupation

Activities were provided by nursing staff with input from OT staff. There was a timetable of activities displayed on the ward and patients were able to access activities within the Bennachie View care building. We were told that some patients access the on-site facilities within the building with their families and/or staff. We were told that the church service is livestreamed every Sunday in the main hall within the building.

The staff record patient activities within a separate recording folder, which details each patient's interests, likes and dislikes. We saw daily recordings of activities occurring and how the activity benefitted the patient. On the day of our visit we saw patients participate in group reminiscence activity.

The physical environment

The ward is situated on the first floor of the building. The design of the building has enabled easy access to the large outdoor garden. The garden was dementia-friendly and had a number of paths, seating areas and raised flower beds. We heard of future plans for the garden area that the OT is taking forward to make the garden area more patient-friendly, so we look forward to seeing this this on our next visit.

All of the bedrooms were large and en-suite. There were separate dining and sitting rooms on the ward and other small quiet seating area for patients to use. We were told that there are plans to utilise further dementia signage around the ward and how the OT is involved in this work also.

Any other comments.

The SCN took up the post five weeks ago and we heard of areas for development that the SCN had already identified. We heard how the ward has developed good links with the community teams and how the new Bennachie care development has enabled some patients to be discharged from the ward to the care home, ensuring appropriate legal authority where required. We were told that the familiar environment has helped when transferring to the care home.

Summary of recommendations

1. Managers should ensure that clear actions are recorded as part of the MDT along with discharge planning activity for individuals whose discharge has been delayed, to ensure this remains focussed and within agreed timescales.

2. Managers should ensure that nursing care plans are person-centred, outlining interventions to meet the identified needs and include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out, and any required changes to meet care goals.

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.

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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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