Mental Welfare Commission for Scotland

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

Date of visit: 1 February 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, we are therefore undertaking a mix of virtual and face-to-face visits. This local visit was carried out face-to-face.

Ashcroft ward is a 10-bedded specialist dementia assessment ward set in the Bennachie View Care Home and Village on the outskirts of Inverurie. Bennachie View comprises of 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 10 patients in the ward at the time of this visit.

We last visited this service on 11 February 2020 and made recommendations in relation multi-disciplinary recording (MDT) and care planning.

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

Who we met with

We reviewed the care and treatment of five patients.

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

Commission visitors

Tracey Ferguson Social Work Officer

Susan Tait, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We were not able to have in depth conversations with all the patients in the ward because of the progression of their illness. However, we did introduce ourselves to a number of patients throughout the day and had a general chat. From our observations, the patients appeared settled in the environment and where there was evidence of stress and/or distress behaviours, we saw nursing staff responding quickly and in a supportive manner.

In patients' files we saw detailed nursing assessments, which provided a good account of the patient's history, the admission circumstances and detailed risk assessments. In each file, we saw 'Getting to know me' booklets that were personalised and gave a good account of the patient's life history.

We saw that patients had good physical health care checks and monitoring and the ward has access to a GP who attends the ward twice weekly.

Multidisciplinary meetings (MDT) are held weekly noting the range of professionals involved in the patients care attends. The SCN told us since the start of the pandemic, more professionals are attending the MDT, as there is now an option to attend virtually, which staff felt was positive. The GP who visits the ward twice a week also attends these meetings to discuss patients physical health care needs, as does the consultant psychiatrist attached to the ward.

We wanted to follow up on our last recommendation regarding MDT records, particularly around discharge planning. We saw detailed recording of MDT minutes in patient files with actions and outcomes being recorded and details of who participated in the meeting. We were told that the ward has developed a discharge recording tool that provides further details regarding patients discharge planning. We were able to view the MDT records in patients' files and found that there was clear and up to date discharge planning or patients who had been identified as ready for discharge.

The ward previously had a full time occupational therapist (OT) attached to the ward, however managers told us that since the pandemic, this input to the ward had changed due to a shortage of OTs across the service area. However, managers and the SCN told us that the OT still has regular input with patients, on a referral basis, and continues to attend the MDT weekly meeting. A referral system continues to be in place should a patient require assessment and/or treatment from an allied health professional (AHP).

We wanted to follow up on the recommendation on our last visit about care plans. We saw care plans that were detailed, and reviewed regularly and where a patient's needs had changed, a new care plan had been put in place. We had further discussion with managers regarding the stress and distress care plans, given that the ward admits patients for assessment purposes and can have stress and/or distress behaviours. We felt that these care plans could be more detailed following the assessment period. The SCN told us that staff are

going to be receiving training on stress and distress behaviours over the next month, which is positive; we would expect to see this evidenced in care plans with more detail on our next visit.

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

Use of mental health and incapacity legislation

On the day of our visit, Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') paperwork in the files was easy to access.

Part 16 (ss.235-248) 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 forms (T3) were in order.

Administration of 'if required' intramuscular (IM) psychotropic medication almost always requires the legislative authority of the Mental Health Act. The Commission is concerned when IM 'if required' medication is being prescribed for informal patients. This is because it is unlikely that there would be consent to receive this treatment if it had to be administered in circumstances where restraint may be required. We consider it best practice for a medical review to be arranged if there are exceptional circumstances where IM medication may be required. We found that there were a few patients who had been prescribed IM medication, and who were informal patients. We had a discussion with managers about this and were told that it can be difficult to receive medical input on an emergency basis in a rural setting and where a patient was displaying distressed behaviours that were challenging; the practice was that the medication was prescribed, however not always used. We discussed a patient's care and treatment where by IM medication had been administered and had concerns about the legal authority that was not in place to ensure safeguards for this patient. Following this discussion we agreed to have a further discussion with our medical colleagues at the Commission and will follow this up with managers of the service.

Recommendation 1:

Managers should ensure intramuscular 'if required' psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances.

We plan to have a follow up meeting with the service to discuss the above recommendation.

On our visit we discussed with managers that a copy of all treatment forms should be kept along the drug prescription sheet. We had mentioned this on our last two visits and were disappointed to see that this was not implemented.

Recommendation 2:

Managers should ensure that copies all treatment forms, T3, Section s47 certificate, treatment plan, and covert medication pathway be stored with the drug prescription sheet.

For patients who had covert medication in place, not all appropriate documentation was in order, as most had no recording of reviews or the pathway where covert medication was considered appropriate. The Commission has produced good practice guidance on the use of covert medication at:
https://www.mwcscot.org.uk/node/492

Recommendation 3:

Managers should ensure that the appropriate documentation is completed all patients who are given medication covertly.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act ('the AWI Act') must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. Nearly all AWI Act section 47 consent to treatment certificates were in order, along with accompanying care plans. We brought this to the manager attention on the day.

Where a patient had an appointed proxy decision maker in place under the Adults with Incapacity (Scotland) Act 2000, we found power of attorney (POA) documents in place. However, we noted that there were a few patients where it had been recorded that there was a POA in place but no copy of the order was in the file. It was unclear if there was a person appointed with the appropriate legal authority, so we brought this to the manager's attention.

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 take whatever steps possible to establish the wishes of the patient. We saw DNACPR's in place for some patients and consultation was recorded with the POA or family member.

Recommendation 4:

Managers should ensure that when a welfare proxy is in place for a patient/resident, a copy of the document stating the powers of the proxy should be held in the case notes.

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 this was on display. The ward has alarm sensors in patient rooms that are used to alert staff when patients are at risk of falls and require assistance.

Patients have access to Aberdeenshire North East Advocacy service who have a good rapport with the ward.

Activity and occupation

Previously the OT would have delivered some of the activity sessions, along with nursing staff, however activities are now being provided solely by the nursing staff. Staff told us that the OT has produced guidance to assist staff in delivering sessions for patients with dementia, and that they have found this helpful. There was a timetable of activities displayed on the ward, although unfortunately due to the pandemic, patients were no longer able to access activities in the Bennachie View care building.

The staff record patient activities and how the activity benefitted the patient, along with patient interests likes/dislikes. On the day of our visit we saw patients participate in group activity and staff offering one-to-one support.

The physical environment

The ward is situated on the first floor of the building, however since the pandemic, the entrance has changed and visitors now have a separate entrance from the care home. Patients have access to a large outdoor dementia-friendly garden. We had previously heard of future plans for the garden area that the OT was taking forward however, due to the pandemic, this work has been put on hold. Staff had a concern about part of the garden that was fenced off and there were concerns around the stability of this fence. Managers informed us that they will look into this and address the matter.

All of the bedrooms were large and had en-suite shower rooms. There were separate dining and sitting rooms on the ward and a further small quiet seating area for patients to use. We were aware that there had been a previous environmental functional assessment carried out in the ward, and the OT had identified areas, particularly around ward signage to make it more dementia friendly. However due to the pandemic no further changes have been made. Managers agreed to revisit the functional assessment to review what works had been identified and take this forward. We look to hearing about these changes on our next visit.

We discussed with staff that it would be beneficial for patients to have displayed on their bedroom door, an identifiable object or picture that the patient can perhaps relate to, to support them around the environment and help identify their room.

Any other comments

On the day of our visit we discussed with the lead nurse, the SCN and other members of the nursing team about their understanding of the Mental Health Act and the AWI Act. We were able to advise that in order to promote leadership and multiprofessional working, a robust knowledge of the Acts would be beneficial for the team. We were pleased to hear that the lead nurse and the SCN for Ashcroft will take this forward.

Summary of recommendations

1. Managers should ensure intramuscular 'if required' psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances.

2. Managers should ensure that copies all treatment forms, T3, Section s47 certificate, treatment plan, and covert medication pathway be stored with the drug prescription sheet.

3. Managers should ensure that the appropriate documentation is completed all patients who are given medication covertly.

4. Managers should ensure that when a welfare proxy is in place for a patient/resident, a copy of the document stating the powers of the proxy should be held within the case notes.

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.

Suzanne McGuinness
Executive Director (Social Work)

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 Commission 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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