Mental Welfare Commission for Scotland

Report on announced visit to: Brucklay Ward, Fraserburgh Hospital, Lochpots Road, Fraserburgh AB43 9NH

Date of visit: 9 May 2022

Where we visited

At the Commission, due to the Covid-19 pandemic, we have had to adapt our local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was able to be carried out face to face.

Brucklay Ward is an older adult assessment unit for people with dementia. The ward has 12 beds and on the day of our visit there were eight patients on the ward. We last visited this ward on 11 March 2020 and made a recommendation in relation to section 47 certificates.

On the day of this visit we wanted to follow up on the previous recommendation and speak with patients, relatives and staff.

Who we met with

Prior to the visit we spoke with the senior charge nurse (SCN) and locality manager via video call. On the day of the visit we met with a range of nursing and ward staff and the activity coordinator. We also liaised with the local advocacy service.

We reviewed the care and treatment of six patients and spoke to two relatives.

Commission visitors

Tracey Ferguson, Social Work Officer

Gillian Gibson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Throughout the day of our visit, we introduced ourselves to a number of patients on the ward and observed that patients appeared content and relaxed in the ward environment. We were not able to have detailed conversations with all the patients, because of the progression of their illness, however where we managed to engage with patients, they told us that they were happy with their care and were positive about the ward staff. Most feedback from relatives was also positive about ward staff and relatives told us that staff are very caring and the communication is good.

We observed supportive interactions between ward staff and patients during our visit. We were aware from speaking to the staff team throughout the day that they knew the patients well.

The SCN told us about the ongoing staffing challenges in trying to fill vacant posts and we recognise that the recruitment of nurses is an issue nationally; this can be more difficult in rural areas. The SCN told us about continued proactive efforts to recruit staff to vacancies, however the ward regularly uses agency staff at the present time, to ensure safe delivery of patient care and continuity.

Nursing care plans

We saw detailed nursing and medical assessments in patient files which were completed on admission, along with risk assessments. We also saw a very detailed entry on admission in the nursing notes. We were told by the SCN that this was introduced to provide staff with a detailed overview, particularly if staff had not been on shift when the patient was admitted. The SCN told us that she has worked extensively with staff to ensure the importance of the detailed admission record. There was good recording of one-to-one sessions in the notes that had taken place with nursing and other ward staff.

Some files had completed 'Getting to Know Me' booklets; with help from relatives these documents provided good life story of the patient's background.

On reviewing the patient files we saw evidence of good physical health care monitoring. Where covert pathways were in place for medication, we saw appropriate documentation in place, along with good pharmacy input and review.

We saw detailed, holistic care plans in place, that were being reviewed regularly with recorded evaluations and updating of care plans where required. Some patients had a high number of care plans, so we had a discussion with the SCN about this and advised on areas where there could be more amalgamation into fewer care plans. As part of patients' mental health recovery plans, the ward continues to have a good focus on the use of non-medical strategies to reduce symptoms of stress and distress behaviours. These were clearly visible in patients' notes, along with evidence of staff following the care plan and applying these interventions before considering use of medication.

For each patient file that outlined how staff managed patients stress and distress behaviours, we felt the detail recorded in the stress/distress action plan would be better either transferred to the care plan or the documentation kept together in another part of the file.

All patients on the ward had recorded in their care plans that they were unable to sign due to lack of capacity. We were told that discussion is held with relatives and proxies about the care plans, however we felt that it would be good practice to record this on the care plan documentation.

Multidisciplinary team (MDT)

There are three consultant psychiatrists that cover the ward and we were told that multidisciplinary meetings (MDT) continue to take place weekly. The ward continues to have access to allied health professionals (AHP) and psychological services via a referral system.

We saw recordings of MDT minutes in the patient's file with recorded actions and outcomes, however in relation to discharge planning we felt there should be more detailed recording regarding progress towards discharge. We were told that there are four patients who have been assessed as being medically fit for discharge. Although progress has been made, with plans in place, we advised on the day of our visit that good practice would be to set an early pre-discharge meeting date to allow all MDT, including the social worker/care manager, to attend.

Where patients required input from AHP's, we saw input from physiotherapy, dietetics and occupational therapy.

Use of mental health and incapacity legislation

On the day of our visit five patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

Of those patients subject to compulsory treatment, we reviewed the legal documentation available in their files and found that all Mental Health Act paperwork was in order.

All authorising treatment forms (T3) under part 16 of the Mental Health Act, completed by the responsible medical officer to record non-consent, were available and in order.

For patients 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 legal order in place.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 AWI Act. We saw that all patients had a completed s47 certificate, and were pleased to see that treatment plans had been completed in accordance with AWI Act code of practice for medical practitioners and the doctor had consulted with the legal proxy.

We were aware of one s47, where it has been recorded on the treatment form that the patient lacked capacity to make welfare decisions regarding care placement. A section 47 certificate

provides authority only for medical treatment under part 5 of the AWI Act and does not provide legal authority regarding welfare decisions. As this was a concern, we brought it to the SCN's attention. The SCN told us that s47 certificates and treatment plans can be often completed by the GP or hospital prior to transfer to Brucklay. The SCN agreed to attend to this matter and ensure a new s47 is completed.

Our AWI good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/1638

On reviewing patient's notes, we were pleased to see that staff had recorded specific legal orders that patients were subject to under AWI legislation. This made it clear regarding the legal authority that was in place in respect of individuals' welfare decisions. However, there were a few entries which recorded "subject to AWIA"; we brought this to the SCN's attention on the day of our visit as we consider this lack of clarity could lead to confusion amongst clinical staff.

Rights and restrictions

The ward has a locked door policy in place and we saw individual risk assessments that identified patients who due to their vulnerability and progression of their illness, would be at risk if the door was opened. The ward door was secured by a magnet and the staff had the code to open the door. We noted that the policy was not displayed on our visit, although the SCN told us that patients keep removing the notice.

The ward continues to have good links with the local advocacy service, who visit patients on the ward and support patients with their rights.

All patients have a falls assessment and care plan in place which is reviewed regularly and the ward continues to use a mobility triangle symbol system for patients who have these specific needs. This enables staff to quickly see the patient's mobility status.

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

The ward has a full time activity coordinator in place. We heard from the SCN and ward staff how the activity co-ordinator has made a significant difference to patient care. On our last visit this post was not in the permanent staffing establishment, however we were pleased to hear that this is now a permanent post. It was positive to see and hear how the benefit and focus of activities continues to be recognised in managing stress/distress behaviours. During our visit we saw that doll therapy was being used with some patients to manage distress behaviours and we heard how effective this was.

The activity co-ordinator told us that she works four days per week and is flexible in her approach at organising and carrying out activities in groups, or on a one-to-one basis. Many of the patients on the ward were receiving one-to-one activities and the coordinator told us that this can change depending on the activity assessment with each patient. A weekly

timetable of group activities was displayed on the wall in the ward, which consisted of therapet, balloon throwing, reminiscing, chair exercises, arts and crafts and music.

In the case notes, we were able to see clear documentation of activities that had taken place and regular review of these with patients. We observed that in patients' notes, there was various documentation relating to activities and therefore perhaps a review, and streamlining of this would be beneficial.

The physical environment

The ward is bright and well maintained with good use of space, for example the use of a seating area in the corridor between the patient bedrooms and the dining room.

There is a combination of dormitory and single bedrooms allowing for a degree of flexibility according to patient's needs. There is also a separate shower room and bathroom, along with an open plan dining/sitting area in the ward which had a door that leads out to the large enclosed outdoor garden area. We were told that the garden was a good resource during the restricted periods that started with the Covid-19 pandemic; this space enabled patients to meet with their relatives in the garden.

Any other comments

While we were aware of the challenges faced by patients in relation to the Covid-19 pandemic, we were equally aware of the impact the Covid-19 pandemic has had on staff. We were impressed to see and hear that the staff have continued to provide a quality service despite the numerous challenges presented to them, including staff shortages. We were also pleased to hear that the SCN has identified two staff members to attend training for trainer's events in relation to stress and distress behaviours.

Service response to recommendations

The Commission made no recommendations, therefore no response is required.

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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