Mental Welfare Commission for Scotland

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

Date of visit: 17 January 2023

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 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 unannounced 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 (HSCP). On the day of our visit, there were no vacant beds.

We last visited this service on 1 February 2022 and made recommendations in relation to intramuscular medication, covert medication pathway documentation, storage of treatment certificates, and for the ward to ensure they had received copies of power of attorney and guardianship documents. The service provided the Commission with an action plan as to how these recommendations were going to be met, so on the day of this visit we wanted to follow up on these, and see how the service had implemented them.

Who we met with

When we plan a visit, prior notice is given to patients and relatives of our intention to visit. Given that this visit was unannounced, we were unsure if we would have the opportunity to speak with relatives, however we were pleased to speak with five relatives and we reviewed the care and treatment of four patients.

We spoke with senior charge nurse (SCN), the charge nurse (CN), other nursing staff and the lead nurse. We had a separate meeting following our visit with the location manager, chief nurse, consultant psychiatrist and clinical lead for older people's services.

Commission visitors

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

On the day of the visit, there were nine patients on the ward and one patient on pass. We introduced ourselves to all the patients and chatted to them throughout the day. We were not able to have in-depth conversations with all the patients in the ward, because of the progression of their illness, however some patients told us that that they were happy and talked about their past hobbies and work. From our observations, the patients appeared settled in the ward and where there was evidence of stress/distress behaviours, we saw nursing staff responding quickly and in a supportive manner.

From speaking with the staff, we gained a sense that they knew the patients well. Some relatives told us that they visited the ward at specific times during the day in order to support their loved ones during meal times. Relatives told us that the staff team supported their continued need to be involved. Some relatives told us that due to the progression of the illness, communication could be difficult with their family member and being involved in activities or other tasks helped them to still be a part of their relative's life.

The feedback from relatives was mainly positive. Most relatives told us that the communication from nursing and medical staff was good and provided us with examples of this. Relatives told us that staff listened to them, and that they were caring and approachable; other relatives told us that they found the ward welcoming. We heard from some relatives of their anxiety of having to move their loved ones on from the ward, as they no longer required hospital-based care. Relatives told us they found this difficult, due to the fact their relative was settled, the staff knew them well and were being caring for. Some relatives told us how the care manager and ward staff have been supporting them with discharge processes.

We had spoken with a relative who shared some concerns about a patient's care and treatment. The feedback was around a lack of communication and engagement with nursing and clinical staff and disagreement about medication. We followed up on this on the day of the visit and will continue to do so where necessary.

The SCN told us that since our last visit, staffing vacancies had reduced, meaning the ward now had a regular staff team in place, providing continuity with patient care. We were also told that one of the charge nurses was due to return to the unit, which will enhance the leadership team in the ward.

The SCN told us that all the health care support worker posts that have been regraded; staff told us they were pleased about this and felt valued for the role they undertook. We wanted to find out about the training that staff had undertaken around stress/distress behaviours, given that this was discussed on our last visit. We were told that one of the CNs had undertaken the stress/distress facilitator training and some staff had attended the training and others had upcoming dates.

Care planning

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

When we last visited the service, we found examples of detailed and person-centred care plans that addressed the mental health and physical health needs of the patient, with evidence of care plans being reviewed and updated where necessary. However, given that the ward admits patients for assessment purposes, who could experience stress/distress behaviours, we felt that more detail was required in the stress and distress care plans.

For this visit, we found detailed person-centred care plans and an improvement has been made in the stress/distress care plans, along with the recorded use of non-pharmacological interventions. We were told about the ongoing staff training and development in this specific area, which was positive, and we look forward to an update from managers about this on our next visit.

When we reviewed the care plans we found that reviews were being undertaken regularly however some of these lacked detail. We found examples where a patient had been admitted several months earlier, had undergone an assessment, although it was often recorded in the review 'no change' or 'remains the same'. We also found some examples where following review, care plan changes were identified and updated on the original care plan, which was confusing. We advised the SCN that some care plans needed to be re-written, especially after multiple additions on the original document. It was unclear if the patient's care plans had been shared with their relative or legal proxy or of their involvement in developing such plans as there was no recording of this in the file.

The unit did not have a named nurse system in place so we wanted to find out about the process that was in place to ensure that care plans were updated, meaningfully evaluated and reviewed. We were told that as the unit only admitted a small number of patients, all staff shared this responsibility and that two patient care plans were reviewed daily, allocated by the shift leader. We discussed this further with the SCN and lead nurse on the day of the visit.

We are aware that care plans, reviews and evaluations are continuing to be worked on and that progress has been made, which is positive. With the added role of the lead nurse to the leadership team and identified training to support staff, this should ensure that the standard of documentation is of high quality, which ultimately benefits the patient experience.

We were aware that other units across NHS Grampian had a named nurse system in place, which identified who was responsible for coordinating patient care from admission to discharge. We suggested to the SCN and lead nurse that a review of the current process was needed.

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/node/1203

Recommendation 1:
Managers should establish a robust audit process to ensure care plans reflect and detail interventions which support patients towards their care goals and that there is evidence of regular review and summative evaluation.

Recommendation 2:
Managers should ensure that care plans evidence patient and carer participation.

Multidisciplinary team (MDT)

The MDT meeting continued to be held weekly and the GP visits the ward twice a week and attends those meetings to discuss patients physical health care needs, as does the consultant psychiatrist attached to the ward.

The ward previously had a full time occupational therapist (OT), although managers told us that since the Covid-19 pandemic, this input to the ward had changed due to a shortage of OTs across the service area. However, we heard from managers and the SCN that the OT still had regular input with patients, on a referral basis, and continued to attend the MDT weekly meeting, where necessary. A referral system had to be put in place should a patient require assessment and/or treatment from an allied health professional (AHP).

We heard that meetings had been held online during the Covid-19 pandemic restrictions and that this had enabled more professionals to attend. We were assured that family members who wished to attend, but were not keen on using the online facility had continued to be given the opportunity to attend in person and we saw evidence of where this was happening.

The ward has two records of the MDT meeting, one kept in the clinical notes and one in the nursing notes. We are aware that at some point there is a plan to move to electronic records which will hopefully address any duplication.

We viewed the discharge planning records and the progress that has continued to be made on a weekly basis, however we were told that all 10 patients were fit for discharge and had been placed on the delayed discharge list. Some patients have been assessed as fit for discharge since September 2022; for other patients, it has only been a matter of weeks. Given that the unit only admits 10 patients, we were concerned to hear that that all patients were ready for discharge, but most did not have a discharge plan in place due to either lack of available resources, such as care packages or care home placements. The Commission had been made aware of the significant pressure on in-patient beds for people with dementia across the Aberdeenshire area due to care home closures following the Covid-19 pandemic, along with the reduction of in-patient beds following the temporary closure of Glen O'Dee Ward in Banchory. We discussed this further with managers and were told that the situation has continued to be escalated to senior managers and that there are daily meetings and discussions. We were told that the service was looking to appoint a care manager to specifically assist with delayed discharge work across the area and we look forward to hearing about this initiative. We were also aware that the older peoples review recently re-recommenced and we will continue to link in with managers about the outcome of this review.

Use of mental health and incapacity legislation

On the day of our visit, no patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

On our previous visit, we discussed with managers, and made a recommendation that a copy of all treatment forms should be kept together along the drug prescription sheet. We were pleased to see that this practice was now in place and found section 47 certificates and covert medication pathway documentation in the drug prescription sheet folder.

For patients who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000 (AWIA), we saw copies of the legal documents, however they were not all easy to locate. We had a further discussion with the SCN about this, given there is a legal section in the person's file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan under section 47 of the Adults with Incapacity 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. Where there is a proxy decision maker in place with powers relevant to the medical treatment, and the practitioner completing the section 47 certificate is aware of that, the practitioner must seek the proxy's consent to the treatment (unless it is not reasonable or practicable for them to do so) and record this on the form. We wanted to review treatment certificates in place and viewed all Adults with Incapacity Act section 47 certificates and treatment plans, however we were concerned about the varying standard of the certificates and treatment plans.

We found some that were very detailed and completed in accordance with the Adults with Incapacity Act code of practice for medical practitioners, however others lacked this level of detail. We found certificates to be incomplete and treatment plans not specific in regards to the treatment that the patient was receiving. We found that where there was a legally appointed proxy, with relevant powers, in place, that they were not always consulted. This was concerning particularly as all patients were being treated under adults with incapacity act legislation. Where a proxy decision maker has specific powers in regards to consent to treatment for a patient and disagrees with the treatment, there is a dispute resolution process in place under Section 50 of the legislation, where a second opinion can be requested from the Commission. We found this is one particular case where there was no consultation with the proxy when the certificate was completed and the proxy disagreed with the treatment plan. It was unclear where proxy decision makers were consulted or if they were in agreement with the treatment plan. Although the service had ensured that the treatment certificates were kept together with the drug kardex, we were told that there was no audit of these. We followed up on our previous recommendation in relation to Intramuscular (IM) medication. We were told that since our last visit, the use of IM medication had not been administered or prescribed for patients. We will continue to follow up on this matter with managers of NHS Grampian and managers of the HSCP.

Recommendation 3:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with Adults with Incapacity Act code of practice for medical practitioners and ensure that these are regularly audited.

Rights and restrictions

Ashcroft ward continued to operate a locked door, commensurate with the level of risk identified in the patient group. There was a secure entry to the ward, accessed by a doorbell entry system and there was a locked door policy in place. The ward had alarm sensors in patient rooms that were used to alert staff when patients were at risk of falls, and required assistance. The staff use these alarms to help manage individual risk.

We heard from relatives that the alarms tend to go off quite frequently and were loud. This was evident on the day of our visit where the alarm was activated frequently and going off until the staff member deactivated it. We were aware of an incident where the sensor appeared not to have activated following a patient's fall; managers agreed to look into this. Given patients with dementia can display stress/distress behaviours, we felt that the noise of the alarm could impact on patient's distress. Managers told us that they had previously looked into this however due to the ward being in a HSCP building and not an NHS premises, the system in place was for the whole Bennachie View care facility and not solely for the ward. We discussed other systems that are in older people's service where staff are alerted without setting off a noise alarm. The locality manager agreed to look into this matter further and we will look for an update regarding this.

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

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 had been unable to recruit to the post of activity coordinator and at the time of our visit, nursing staff and health care support workers provided group and one-to-one activities on the ward. Prior to the Covid-19 pandemic, the OT provided some sessions but this no longer happened, however the OT had produced guidance to assist staff in delivering sessions for patients with dementia, and staff had found this helpful. We saw activities happening on the day and patients enjoying these. We saw one-to-one therapeutic activities being provided to support a patient with stress/distress behaviours. The staff recorded patient activities and detailed how the activity benefitted the patient, along with patient interests and likes/dislikes.

Therapeutic activities are important to support patients with their stress/distress symptoms and we heard from staff about the benefit and focus of activities, however we also heard that the competing demands on nursing staff's time can impact on the delivery of activities. The ward is continuing to recruit for the activities coordinator post and we look forward to getting an update on our next visit.

The physical environment

The ward was situated on the first floor of the building, and since the Covid-19 pandemic, the entrance for visitors had changed. There was a separate entrance from the care home and we were told that this entrance was likely to continue for the foreseeable future.

Patients had their own en-suite bedroom that provided them with privacy and dignity. The bedrooms were large and had accessible en-suite shower rooms. There were separate dining and sitting rooms on the ward and ample space for patients to sit or freely wander. We requested an update from managers regarding the previous environmental functional assessment that we were told was carried out prior to the Covid-19 pandemic. The OT had identified areas, particularly around ward signage to make it more dementia-friendly. Managers agreed to revisit this following our last visit, however we heard that this had not been taken forward. The ward lacked signage for people with dementia to support them to navigate around the environment and there were no identifiable objects or pictures to assist patients to their bedrooms either.

We had discussed with staff on our last visit 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.

Patients had access to a large outdoor dementia-friendly garden and we wanted to follow up on the recommendation from our last visit regarding an outdoor fence. We were pleased to see that this had been addressed and we were able to see the new fence on the day of the visit.

Recommendation 4:
Managers should ensure that the environment has dementia friendly signage and consideration is given to ways in which to help patients identify their own bedrooms.

Any other comments

Since our last visit, we have continued to follow up with managers of NHS Grampian and the HSCP regarding the concerns with the use of intramuscular medication that we had highlighted on the previous visit report. We undertook visits to other dementia units across NHS Grampian, and we found that intramuscular medication was being prescribed and administered to patients who were not detained under the Mental Health Act and that there were inconsistent practices and understanding of the legal authority regarding the prescribing and administration of the intramuscular medication for patients who lacked capacity and were not detained under the Mental Health Act. We wrote to managers in NHS Grampian and to the chief officers of the HSCP's. We had follow up meetings, providing advice and good practice guidance to the managers. We continue to follow up on this matter as we are aware that NHS Grampian is in the process of reviewing their rapid tranquilisation policy and we would expect to see this good practice guidance incorporated into the policy.

We were told that since our last visit to the service, there is now an operational lead mental health nurse in older people's services, providing support and leadership across the community and in-patient services in Aberdeenshire. We were told that the lead nurse will be taking forward some training aspects around Adults with Incapacity and Mental Health Act

Legislation. The Commission published the Authority to Discharge report in May 2021 recommending that HSCPs undertook a full training needs analysis to identify gaps in knowledge in relation to Adults with Incapacity legislation. The Commission has continued to link in with HSCP's regarding the recommendations from this report, to ensure that these are being met. It is important that the lead nurse liaises with the HCSP about identified training gaps so there is a collective approach in moving forward to better enhance the workforce's knowledge base. The Scottish Government provided funding to develop an Adults with Incapacity framework for staff and this is being progressed jointly by the Commission and NHS Education for Scotland (NES). We will continue to keep the HSCP's and NHS Grampian appraised of this development.

Summary of recommendations

Recommendation 1:
Managers should establish a robust audit process to ensure care plans reflect and detail interventions which support patients towards their care goals and that there is evidence of regular review and summative evaluation.

Recommendation 2:
Managers should ensure that care plans evidence patient and carer participation.

Recommendation 3:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with Adults with Incapacity Act code of practice for medical practitioners and ensure that these are regularly audited.

Recommendation 4:
Managers should ensure that the environment has dementia friendly signage and consideration is given to ways in which to help patients identify their own bedrooms.

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
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 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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