Mental Welfare Commission for Scotland

Report on announced visit to:

Ashcroft Ward, Bennachie View Care Village, Inverurie AB51 5DF

Date of visit: 21 February 2024

Where we visited

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 in January 2023 on an unannounced visit and made recommendations in relation to Adults with Incapacity (Scotland) Act 2000 (the AWI Act) section 47 certificates, care plan audits, and individual/carer participation. The response from the service included a comprehensive action plan, detailing how those recommendations were going to be met. On the day of this visit, we wanted to follow up on the previous recommendations and see how the service was implementing the actions.

Who we met with

We met with three individuals, reviewed the care records of six people, and met with three relatives.

We spoke with the interim location manager, the senior charge nurse (SCN), ward-based staff, the lead nurses, and consultant psychiatrist.

In addition, we met with independent advocacy service, Advocacy North East.

Commission visitors

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

On the day of the visit there were 10 individuals on the ward. We introduced ourselves to all of them and chatted to them throughout the day. We were not able to have in-depth conversations with all those on the ward, because of the progression of their illness. However, where we were able to have more detailed conversations, individuals told us that that they were “happy on the ward”, staff were “nice” “friendly” and “caring”, and the “food was good”.

From our observations, the ward was calm, and individuals appeared content. Throughout the day we saw positive interactions between individuals and the ward staff. Where there was evidence of stress/distress behaviours, we saw ward staff responding in a caring and supportive manner, using non-pharmacological interventions, which was positive.

When we spoke to ward staff on the day, we gained a sense that the staff team had a wealth of knowledge in supporting individuals with dementia, as well as a strong commitment towards meeting individual outcomes. In terms of service development, we were aware following on from our last visit that the service had recruited a mental health lead nurse and the SCN told us that the service had also recruited a primary care lead nurse. We heard from the SCN that these additional posts to the leadership team had brought a wealth of knowledge and expertise to the inpatient and community settings for the older adult’s service across Aberdeenshire.

Feedback from relatives was positive. Relatives told us that they felt involved in their relative’s care and treatment and received regular updates from ward-based staff. A few relatives told us about meetings that they had attended and that they would know who to approach if they had any issues or concerns. We spoke to one relative where we received some feedback about sharing information and we discussed this further with the SCN on the day of the visit. One relative told us that they were so grateful for the service of a translator to support communication and had received a copy of the translated care plans, which was positive.

Most relatives told us that the communication from nursing and medical staff was also good and provided us with examples of this. Relatives told us that they could visit the ward at most times of the day and that the staff made them feel very welcomed.

The SCN told us they had employed an activity coordinator, however, this position has recently had to be re-advertised, as the person has left the post. We were told that there were now two part time charge nurses in post, and the ward only had one vacant staff nurse position. Where there were gaps in shift cover, the SCN told us that they used regular bank nurses, and these were often retired nurses who had previously worked in the ward and had the relevant experience.

We received positive feedback from Advocacy North East. We were told that the staff were welcoming, helpful, and approachable and that the staff were supportive of the principles of advocacy and to the benefits of this support for individuals. Advocacy also shared some positive feedback from relatives’ experiences and one individual, who had previously been admitted to the ward, described the staff as “their new family”.

Care, treatment, support and participation

In the medical and nursing files, we saw assessments that were detailed, and provided a good account of the history and circumstances that led to the individual's admission, along with detailed risk assessments. In each file, we saw 'getting to know me' booklets that gave a good account of the person's life history, and some of this information was incorporated into other documentation, such as care plans and one-page profiles.

We found that the daily nursing records were detailed, meaningful, and provided an update on each individual's progress, along with evidence of links to the care plans.

We wanted to follow up on last year's recommendation about care plans, as we had previously found there was a lack of detail in the care plan review process. The SCN and lead nurse told us that the ward now had a named nurse system in place that ensured the care plans were compiled, implemented, reviewed, and evaluated on a regular basis. We were told that a standard operating procedure was devised by the nurse consultant and there was now a monthly audit system in place. We heard that this process, along with the documentation, would continue to be reviewed and discussed, to ensure that there is a consistency in the standard of high-quality records being maintained.

On our visit we were pleased to see the progress made. We found care plans that were detailed, holistic, and covered a wide range of individual needs, with evidence of regular and meaningful reviews. We found examples where care plans had been updated following reviews, and all the care plans that we looked at were signed and dated either by the appointed legal proxy or by a relative, which was positive. Where a person's first language was not English, we saw care plans that had been translated to their preferred language and the relatives received a copy of these. However, we felt that there should have been a separate care plan specifically for communication; the SCN agreed to take this forward and seek input from speech and language therapy.

We found that the stress/distress care plans were detailed and evidenced the use of non-pharmacological interventions; however, we did see one care plan where it recorded the 'use of distraction techniques', but there was no detail as to what the techniques were. We discussed this with the SCN and advised that the quality of recording should be picked up during the audit process.

The Scottish Government produced a revised policy on 'do not attempt cardiopulmonary resuscitation' (DNACPR) in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf).

This policy makes it clear that where an adult cannot consent and has a welfare guardian or 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 whatever steps are possible to establish the wishes of the individual. From the files that we reviewed we found that DNACPR forms had clearly recorded where proxy decision makers and families had been consulted.

Multidisciplinary team (MDT)

The MDT meeting continued to be held weekly and the GP who visited the ward twice a week attended these meetings to discuss individuals' physical health care needs. We were told that since our last visit, the ward had an additional consultant psychiatrist join the team.

We were told that individuals continued to have full access to allied health professionals, and we saw from reviewing the files where individuals had ongoing input from physiotherapy, dietetics, and occupational therapy. We discussed one person's care, where we felt they would benefit from a physiotherapy assessment and the SCN agreed to take this forward.

Although family members do not attend this meeting, we were assured that there were separate family meetings held and we saw evidence of this in the files.

The ward continued to have two records of the MDT meeting, one kept in the clinical notes and one in the nursing notes; both were of a good standard. We are aware that at some point there is a plan to move to an electronic record system, which will hopefully address any duplication and where there will only be a need to complete one record.

We were told that there were six individuals who had been assessed as ready for discharge and able to move on, although some of these individuals have been waiting for some time, and for others, it had been a matter of weeks. We were aware that there had continued to be a concern about the lack of placements in the Aberdeenshire area, due to care home closures following the pandemic, along with the reduction of inpatient beds at Royal Cornhill hospital and the closure of Glen O'Dee ward in Banchory. We heard again of the significant pressure on inpatient beds for people with dementia across the Grampian area and were aware that the situation continued to be discussed in the HSCP. We were told on our visit last year that the service was looking to appoint a care manager to specifically assist with delayed discharge work across the area and that this had happened however, the post was only temporary and was now vacant. From speaking to ward based staff, managers, and families, we heard how everything appeared to be getting done to support discharge, but the hold-up was merely down to the lack of placements in the area.

We also heard how families were not keen to move their loved ones out of area. The staff have continued to record progress of individual delays in a separate folder, and although we found regular recordings, we found that these were inconsistent. We advised the SCN that where an individual may be waiting on a placement, regular recording in this folder would aid the tracking of this from a ward perspective. We were told of the regular meetings that occurred across the HSCP to look at all delayed discharges.

We were aware from our visit to Skene Ward in Royal Cornhill Hospital, last year that the older people's review was placed on hold due to other pressures across the service; we will continue to seek updates from senior managers about when this is likely to be restarted.

Use of mental health and incapacity legislation

On the day of our visit, two individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was easily accessible in the files and 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 legal order in place, which was easily accessible in the files. Where a person had a power of attorney in place, we suggested that it would be good practice to record in the person's file if the power of attorney had been activated or not, depending on the person's assessed capacity.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

We wanted to follow up on our recommendation from last year about the AWI Act section 47 certificates and treatment plans. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan 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 Act. The doctor must also consult with any appointed legal proxy decision maker, who has relevant powers and record this on the form. All individuals had a section 47 certificate in place, along with a treatment plan and there was evidence that the proxy decision maker had been consulted with, which was positive. We were told that all treatment forms were discussed in the MDT meeting on a weekly basis, which was positive to note, as was the standard of completion. We were aware that individuals were often transferred to the ward from another hospital and this regular review allowed for any prompt action taken to be taken if clinical staff were dissatisfied with the details on the certificate.

We have continued to follow up on our previous recommendation from our visit in 2022 in relation to intramuscular medication (IM). We were told that since our last visit, IM medication has not been administered or prescribed for individuals who were not detained under the Mental Health Act and that there have been ongoing meetings locally, and with managers in NHS Grampian, to discuss the provision of clinical cover to the ward during 'out of hours' and weekends, given the rurality of the ward. We are aware that NHS Grampian has updated their rapid tranquilisation policy, and we will continue to follow up on this matter with NHS Grampian managers and the HSCP.

Rights and restrictions

Ashcroft Ward continues to operate a locked door, commensurate with the level of risk identified in the group. There was secure entry to the ward, accessed by a doorbell entry system and there was a locked door policy in place and displayed on the door. The ward had alarm sensors in individual rooms that were used to alert staff when an individual may be at risk of falls and if assistance was required. The staff could use these alarms to help manage individual risk. Although we heard alarms being activated, we saw staff respond quickly to this.

Following our last visit, the locality manager agreed to look into the alarm system that was in place, given individuals with dementia can often display stress/distress behaviours that may be related to noise. Unfortunately, as the location manager had recently left post, there was no further update however, the interim location manager agreed to look into this and we will seek an update.

Individuals had access to Advocacy North East service, who had a good rapport with the ward and regularly visited. One advocate we spoke with told us how they felt welcomed on the ward and that the staff supported the role of advocacy to help with individual rights. We saw the recording of advocacy at individual meetings and other meetings such as Mental Health Tribunals. We were told that the provision of advocacy was not only for individuals who were detained under the Mental Health Act, but also for all those on the ward.

Activity and occupation

We were told that the ward had recruited to the post of activity coordinator however, the post had since become vacant and recruitment processes were underway. At present, the nursing staff and health care support workers continue to provide group and one-to-one activities on the ward. We saw activities happening on the day, and individuals participating and enjoying these. There was a notice board in the sitting area that displayed what activity was happening each day.

Therapeutic activities are important to support individuals with their stress/distress symptoms and we heard from staff about the benefit and focus of activities to this group. We saw the recording of activities in the care records, along with a description of the benefit to individuals however, we got the impression there could be more activities taking place than were being recorded. We were pleased that the ward has continued to invest in an activity coordinator and we look forward to hearing more about this specific role on our next visit.

The physical environment

The ward was situated on the first floor of the building, and the entrance for visitors was separate from the care home part of the building. The ward was bright and welcoming, and individuals had their own en-suite bedrooms 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 and ample space for individuals to sit or freely wander up the corridor. On last year's visit we felt that there was a lack of dementia friendly signage around the ward and that the environment did not support people with dementia to access their own bedrooms. The SCN told us that they had visited the other dementia ward in north Aberdeenshire for ideas and now have in place identifiable objects and/or pictures on individual bedroom doors which we saw on the day of the visit. The SCN told us that this had supported individuals' orientation to their own room, as they recognise the picture. The SCN told us that the plan was to make further changes to the colour of individual doors in the ward area, and this was progressing.

Individuals continued to have access to a large, outdoor, dementia-friendly garden where there was ample space for walking and a patio with seating.

There were two white boards on the wall of the staff room that displayed specific details about each individual such as DNACPR status, legal status, and dietetic requirements. We found that some of this confidential information could be viewed by others, particularly when the door was open. We suggested to the SCN and managers to either move the boards or place screening over the windows of the doors and they agreed to address this as a matter of priority.

Service response to recommendations

The Commission made no recommendations.

However, we would like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved and would ask the service to advise us about how this has been actioned.

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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