Mental Welfare Commission for Scotland

Report on announced visit to: Bennachie View Care Village, Ashcroft ward, Inverurie, Aberdeenshire

Date of visit: 08 April 2016

Where we visited

Ashcroft is a ten-bedded dementia assessment ward set within a new care village called Bennachie View. The ward was formerly located at the Inverurie Hospital site. The ward admits patients from their own homes, care homes and general hospitals in the Aberdeen City and Aberdeenshire areas. We last visited this service in May 2014 and no recommendations were made. This was our first visit to its new location. The ward is supported by a Consultant Psychiatrist in old age psychiatry and has dedicated GP sessions 3 times a week. On the day of our visit Ashcroft was closed to admissions because of an outbreak of an antibiotic-resistant bacterial infection. This limited our ability to interview patients.

On the day of this visit we wanted to look at individual care plans and also look at documentation relating to the Adults with Incapacity (Scotland) Act 2000 (the Adult with Incapacity Act). This is because we sometimes find on visits that the necessary documents are not in place.

Who we met with

We met briefly with 2 patients.

We reviewed 4 case files.

We did not meet with any relatives or carers on the day.

We spoke with the senior manager, area manager, and senior charge nurse for the service.

Commission visitors

Paula John, Social Work Officer (Visit Co-ordinator).

Douglas Seath, Nursing Officer.

What people told us and what we found

Care, treatment, support and participation

Given the infection on the ward there were only 4 patients present at the time of our visit. We were able to read all of the care plans.

We found evidence of multidisciplinary meetings taking place on a regular basis and these were minuted with a note of those in attendance. We were encouraged to see that relatives and carers were invited to attend these meetings.

We were also advised of good links with community services, particularly GPs, social work services and voluntary organisations, all of which assisted discharge planning.

Ashcroft also has strong links with a community outreach team for older people based locally.

Medical reviews by psychiatry took place regularly with additional support from a local GP with special interest and training in dementia. The case files included recordings of these contacts and demonstrated a strong emphasis on physical health care.

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms were in place for patients but displayed clear evidence of consultation with relatives and welfare proxies.

The nursing care plan was a standardised template which did not always lead to person-centred information. It was difficult to ascertain individual needs and strengths from these documents. Life histories were found on each care plan but they contained inconsistent detail in relation to interests and preferences. Reviews of care plans were taking place on a monthly basis but with little evaluation of their effectiveness. There was limited information on care plans on how to manage distressed behaviours. We were advised that there was no dedicated psychology input to the ward, but consultation was available.

Recommendation 1

Managers should ensure that life histories are completed consistently in relation to patients on the ward.

Recommendation 2

Managers should review the use of templates in patient care plans and ensure that they are personalised and reflect and inform the care currently being provided.

Use of mental health and incapacity legislation

There were no patients subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 at the time of our visit.

Certificates of incapacity (s47) under the Adults with Incapacity Act had been completed where required and had accompanying treatment plans. These were all within the relevant timescales and completed appropriately.

For those patients who are subject to welfare guardianship or have powers of attorney, this was marked clearly in the records and copies were held on file.

Rights and restrictions

Due to the nature of the ward there was a secure door entry system. However, there was a locked door policy in place.

There were no patients subject to compulsory measures and staff were not able to identify any patient where there was an unauthorised deprivation of liberty. We did not observe any patient trying to leave the premises during the course of our visit.

We found that some restrictions were in place for patients in wheelchairs as lap belts were used. We were pleased to see that these had clear care plans in place and were used at specific times.

Activity and occupation

We found that patients had access to occupational therapy services and this was by referral to an occupational therapist. We were advised that nursing staff are also involved in providing activities. The patient group on the day of our visit were individuals in the advanced stages of dementia and therefore the range of activities was limited. Care plans did record that these were taking place both on a 1:1 basis and on a group basis. These involved music and art sessions, games and basic reminiscence work.

The physical environment

The ward environment is new and is clean, bright, comfortable and furnished to a high standard. The ward itself is contained in a large building which also accommodates a care home and a ground floor meeting place which can be accessed by the local community.

There is appropriate pictorial signage throughout the building and in the ward itself.

Although it is on the top floor of a two-tier building, Ashcroft can be accessed via a lift. In addition, the patients have access to a large garden which is dementia friendly; it is enclosed and secure with pathways, sheltered spaces and raised flower beds. Patients are able to use the garden and are escorted by nursing staff. There was evidence in the case notes that patients had accessed the garden, weather permitting.

All ten rooms have en-suite facilities, there is a shared living space, dining space with a small kitchen which could be used by staff and patients with the appropriate support bathrooms with hoist and lifting equipment and small meeting rooms.

Attempts have been made to decorate the ward with paintings and photographs of the local area which reflect its agricultural heritage. We were advised by staff that these have assisted in reminiscence work.

Summary of recommendations

1. Managers should ensure that life histories are completed consistently in relation to patients on the ward.

2. Managers should review the use of templates in patient care plans and ensure that they are personalised and reflect and inform the care currently being provided.

Good practice

We were informed of a recent development where GPs with an interest in dementia had received additional training locally and now provided input to the three dementia wards across the Aberdeenshire area. Ashcroft ward benefits from this input. The aim of the initiative is to raise awareness of early intervention in dementia, heighten the experience and knowledge of local GPs and improve the relationship between primary and secondary care.

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 the Care Inspectorate and Health Improvement Scotland, as it is an NHS facility.

Kate Fearnley

Executive Director (Engagement and Participation)

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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