Mental Welfare Commission for Scotland

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

Date of visit: 13 March 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Brucklay ward is a 12-bedded dementia assessment unit based in Fraserburgh Hospital. The ward provides assessment to individuals from North Aberdeenshire; however we were told that there were occasions when individuals have had to be admitted to this unit from other areas of Aberdeenshire, due to bed unavailability in other wards.

On the day of our visit there were 12 individuals in the ward.

We last visited this service in September 2023 on an announced visit and made recommendations about the recording of decisions at the multidisciplinary team (MDT) meetings, ensuring individual rights were maximised, review of the timescale for in-person medical reviews, the completion of section 47 certificates and treatment plans under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), and for the service to ensure that individuals who were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) had regular reviews of their detention.

The response we received from the service was outlined in a detailed action plan. The Commission had a further meeting with the health and social care partnership (HSCP) location manager in June 2024, where an update was provided about the progress of the actions.

On the day of this visit, we wanted to follow up on the previous recommendations and hear about how people's discharges from hospital were progressing.

The senior charge nurse (SCN) told us that she continued to manage the community north dementia outreach team and that there were good links between inpatient and community services, providing a benefit in the overall experience for those receiving care and treatment.

Who we met with

As this visit was unannounced, we were aware that no prior notice had been given to any relatives or individuals. However, on the day, we met with two individuals and reviewed the care of four people. We also met with four sets of relatives.

We met with the SCN, spoke with nursing and other ward staff, the health and social care partnership (HSCP) manager, and the chief nurse for the HSCP.

Commission visitors

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

Throughout the day of our visit, we introduced ourselves and chatted with all individuals in the ward. We were unsure if we would have the opportunity to meet with families, given this visit was unannounced, however, throughout the day, as families were visiting the ward**,** they were happy to speak with us.

We were not able to have detailed conversations with all people, due to the progression of their illness, but we saw that individuals appeared settled in the environment and from our observations, the ward had a relaxed, friendly atmosphere. Where we were able to have a more detailed conversation, one individual told us that they were “happy” being on the ward and described staff as “really nice”. Another described the staff as “lovely” and told us that they were waiting on a placement.

We saw that some people had brought in their own belongings to personalise their bed space in their room. One individual told us that they liked having their own room as this provided them with some privacy.

We saw families participating in the care of their relatives’ routines and joining in activities. Feedback from relatives was positive, where some described the staff team as “approachable”, “brilliant” and “very caring.” Relatives told us that they were happy with the care that was being provided, and that communication was good. Relatives told us that they felt involved in their loved one’s care and treatment and had seen their care plans. Relatives described the staff team on our last visit as the “experts” and it was positive to hear how relatives again described the staff team on this visit as “experts” in the field of dementia, as they felt that the staff team had the necessary skills to support people with dementia and always looked at ways to manage distress without the use of medication.

All relatives described the ward as welcoming and that there was no issue with visiting. One relative told us that they were waiting on a bed becoming available at a unit nearer home, as the unit was quite far away for some relatives to visit, but there was no date provided yet. We discussed this with the SCN and staff who told us that another person was also waiting for a transfer to the same unit, once a bed became available.

From speaking to the staff team, we got the sense that they knew the people well and how best to support them, especially around managing levels of distress and the identified triggers. Where there was evidence of stress and distress behaviours, we saw nursing staff responding to the individual in a supportive and caring manner.

On our last visit, the unit had introduced a twilight shift and we wanted to hear about this. The SCN told us that this new addition had been positive and supportive, as this was a time where individuals experienced higher levels of stress/distress.

Care, treatment, support, and participation

Care records

The SCN and nursing staff told us that some documentation had been transferred to the electronic system TRAKCare, which we knew was being rolled out across NHS Grampian. We accessed individual electronic files on the day of the visit as well as paper files that were still in place.

The SCN told us that the plan was for the unit to eventually have all recording and documents transferred to the electronic system; to be able to view all documentation recorded electronically in one place will be helpful. We were told that the ward-based staff and the consultant psychiatrist recorded all contact with individuals on the electronic system. The weekly MDT meetings were also recorded on this system, along with nursing assessments, risk assessments and risk management plans.

With nursing staff daily recordings now being completed on TRAKCare, we found most of the entries to be detailed, relevant, meaningful, and linked to individuals' care plans. We saw some entries where all that had been recorded was the list of corresponding care plan numbers, but no other detail, which was confusing. We discussed the ones that we felt would benefit from more detail with the SCN.

We reviewed care records that had detailed and completed 'Getting to know me' booklets. With help from relatives, these provided information on the individuals' life stories. We saw positive examples where this information had been transferred into the individuals' stress and distress and activity care plans, particularly around how to manage stress and distress symptoms. On reviewing people's records, we saw evidence of physical health care monitoring throughout their journey. We found completed 'do not attempt cardiopulmonary resuscitation' (DNACPR) certificates that appeared to be in order. We had a discussion with the SCN about one individual's DNACPR that had been put in place prior to their transfer to Brucklay ward. The SCN agreed to follow up with the person's family.

All individuals had multiple care plans in place that covered a wide range of needs and most of the care plans were detailed. As the ward used a template care plan, this meant that some of them were less personalised than others. We were told that care plans were reviewed monthly, however the care plan reviews lacked detail. Most reviews simply recorded 'remains relevant', therefore it was difficult to know if the care plan that was developed on admission was meeting the person's needs. From our review of the care records, as well as speaking to staff and relatives, we found that the care that was being provided was of a high quality and staff had the

requisite skills and knowledge to deliver the care required to individuals in all stages of dementia care. However, this was not always evidenced through some of the documentation.

Recommendation 1:
Managers should ensure that care plan reviews are detailed and provide a summative evaluation of the efficacy of care interventions.

The Commission has published a good practice guide on care plans[1]. 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.

In terms of participation in their care and treatment, all care plans had been signed by relatives, and it was clear to see that relatives were involved and consulted, which was an improvement from our last visit.

The individual mental health recovery plans that we reviewed continued to have a clear focus on the use of non-pharmacological strategies to reduce symptoms of stress and distress behaviours. These were clearly documented in individuals' records, along with evidence of staff following the care plan and applying these interventions, before considering the use of medication.

The SCN told us that staff continued to be released to undertake training in relation to the Newcastle Model, which is a person-centred approach to supporting people who present with stress and distress. This model focuses upon a largely psychological approach, which not only benefits individuals but also their relatives and staff. The model identifies the possible cause for distress and supportive interventions are put in place to reduce behaviours associated with stress and distress. We noted again on this visit the continued investment in the team by the SCN to ensure staff had the necessary skills, knowledge, and tools to support the individuals on the ward.

All individuals had a completed falls assessment and an associated care plan in place, which was reviewed regularly. The ward continued to use a mobility triangle symbol system for individuals who had these specific needs, which enabled staff to quickly view mobility status.

Multidisciplinary team (MDT)
The ward had a locum consultant psychiatrist that covered both the ward, and the community. MDT meetings took place weekly and usually consisted of the consultant psychiatrist and ward staff. We were told that the ward continued to have

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

access to allied health professionals (AHPs) or psychological services via a referral system, and we saw their involvement evidenced when we reviewed records.

A record of the MDT meeting was now being recorded on TRAKCare and we found that both nursing and medical staff completed a separate record but used the same tool. Both had a record of who attended the meeting, along with the actions, outcomes, and a note of who would feed back to the family. The level of detail provided in both documents was positive and nursing staff provided an update with regards to the individuals level of stress/distress and linked the record to Datix incidents. Datix is an incident reporting system that is used in health boards for staff to report any incidents and risks. The reporting system can be used by managers to improve patient safety.

We wanted to follow up on a recommendation from our last visit regarding medical reviews and were pleased to see that the service had implemented a standard time for a medical review to be carried out, which was recorded in the MDT record. However, we found some entries where it was recorded that the consultant psychiatrist had seen the person but we found it difficult to locate the record of the face- to-face meeting. Given that the recording of the MDT was now on TRAKCare and both professionals were using the same template, we suggested to the SCN and managers that it would be good practice to have one recording of the MDT meeting instead of two. This would reduce duplication and provide a more integrated formal meeting record, including discussions, outcomes and ensuring individual and relatives views are incorporated as part of this.

The ward had input from psychology, and we heard that the psychologist continued to provide training to staff around dementia care and managing stress and distress behaviours.

We were told that the ward currently had seven individuals who were awaiting care home placements and were reported as having their discharge from hospital delayed. Although most individuals had been assessed as delayed fairly recently, we found that one individual's discharge had been delayed for several months. The SCN had also informed us that there were two individuals awaiting transfer to Ashcroft ward, a specialist dementia unit in central Aberdeenshire. We were pleased to hear that there were positive links with the social work teams and that social workers and mental health officers would attend meetings, where appropriate.

We were however, concerned to hear about the number of people delayed in hospital, given it is not a home. We had a further discussion with the SCN and HSCP managers about this. We were aware that there has been a shortage of placements across north Aberdeenshire, and more so since the Covid-19 pandemic. We were also told that due to the HSCP financial budgets and constraints that they required to

make significant savings, thus impacting on the amount of care home placements that were able to be funded at any given time.

Given this has an impact not only on bed provision across the older adult inpatient beds in Grampian but also on individual discharges, we will follow this up and have further discussion with senior managers.

Use of mental health and incapacity legislation

On the day of our visit there were no individuals subject to detention under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). For individuals who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), we saw copies of the legal orders in place.

We wanted to follow up on our recommendation from last year where we found that not all section 47 certificates and treatment plans were completed in accordance with Part 5 of the AWI Act code of practice for medical practitioners. 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 Act.

All individuals had a completed section 47 certificate in place, and these were easy to locate in the care records. We found one that had expired and brought this to the SCN's attention. While all had a treatment plan in place, some were more detailed than others.

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). A welfare proxy can be a welfare power of attorney, welfare guardian or, less frequently, a person authorised under an intervention order. The AWI Act provides that a section 47 certificate does not confer authority to treat if the person issuing the certificate is aware that there is a welfare proxy, and they have failed to obtain the consent of the proxy when it would be reasonable and practicable for them to do so.

We saw some certificates where proxies had been consulted with and this was recorded on the certificate. However, we found others where the doctor had ticked the part on the certificate that it was not practicable at that time to consult. The record did not indicate when this was to be followed up and by whom. Therefore, it was unknown if proxies were fully aware of their relative's treatment.

We had a further discussion with the SCN and managers about this, given this was a recommendation made from our last visit. We were informed that where an individual was transferred to Brucklay Ward from another hospital, with a completed section 47 certificate, that the certificate was reviewed by the consultant psychiatrist and accepted or not. We found the certificates by the psychiatrist attached to the ward were completed in line with the code of practice and the ones that were not tended to be completed by other doctors from other hospitals.

As some of these had recorded reasons for no consultation with the proxies due to emergency, there were no records as to who was going to follow this up or recorded on transfer paperwork to Brucklay Ward.

Recommendation 2:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with the AWI Act code of practice for medical practitioners and that certificates are reviewed when a person is transferred to the ward and that consultation processes with proxies have taken place when practicable and recorded.

Where covert pathways were in place for medication, we saw appropriate documentation in place, along with ongoing review.

Rights and restrictions

The ward continued to operate a locked door, which appeared to be commensurate with the level of risk identified in the group of people in the ward. The locked door policy was displayed on the inside door in the ward, along with information displayed on the outside door to the ward.

The ward had good links with the local advocacy service and there was information available on the ward about this service for individuals or relatives to access.

Where a person was subject to continuous intervention, we would expect there to be a care plan in place that was reviewed, in line with NHS Grampian observation policy. One individual was on continuous observations, and there was a specific care plan in place, which was positive to see.

We wanted to follow up on our recommendation from our last visit regarding the MDT decision making with regards to care provision and maximising the rights of people who are admitted informally. The SCN told us that the incident reporting system, Datix, continued to be used to record adverse incidents that occurred on the ward, that involved individual(s). We found that these were brought to the weekly MDT meeting for discussion, with a particular focus on the ones around the use of pharmacological interventions, and the reasons for this.

Given that the ward admitted people with a diagnosis of dementia for assessment, we recognised that the staff team were managing a high level of stress and distress behaviours on the ward. We were pleased to see that discussions were happening at the MDT meeting and that the service had a robust action plan in place to meet this recommendation. We will continue to monitor this on future visits.

When we are reviewing care records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any advance statements on the ward and understood this was due to people's inability to engage in the process due to the advancement of their illness.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

The ward had recently recruited to the vacant activity co-ordinator post. On our previous visits we had found that there was a clear focus on the importance of activities in managing stress and distress symptoms and again, we found this to be the case on this visit. Even although the post had been vacant, we found that there was still lots of activities being provided in a group and an individual basis, dependent on individual needs.

It was positive to see and hear how the benefit and focus of activities continued to be recognised in managing stress/distress behaviours in the ward.

On our last visit we heard how the ward had purchased a wheeled television where individuals could watch a TV programme remotely or access applications on the internet to generate discussion during a one-to-one or group session. We saw this being used during our visit. We were able to see activities being offered and recorded in the care records, but we got the impression that there were more activities happening that were not always being captured in the daily recordings.

Everybody had a completed a physical activity level (PAL) in their care record that incorporated a profile linked to their life story, enabling activities to be tailored to individual needs.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

The physical environment

The layout of the ward consisted of a combination of dormitories and single en-suite bedrooms, allowing for a degree of flexibility according to individual needs. Each dormitory had a large, accessible bathroom. There was also a separate shower room and bathroom, along with an open plan dining/sitting area in the unit which had a door that led out to the large enclosed outdoor garden area.

The garden area was well maintained, and we were told that the garden was a great resource for individuals and staff to use.

The ward had lots of artwork displayed on the walls, which were all focal points of Fraserburgh. Staff told us that the pictures had enabled conversations with people, as they had recognised landmark areas. There was signage in place to support people to navigate around the ward and each person's name was displayed beside the door or above their bed. Each single room had a different colour of door however, we saw that the laminate was peeling off most of the doors.

Recommendation 3:
Managers must replace the laminate covering on all the single ensuite doors.

We heard that individuals were able to bring in some personal items if they chose to and relatives would discuss this with nursing staff. The ward had a warm and welcoming environment, which was clean and bright, with space for people to wander.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plan reviews are detailed and provide a summative evaluation of the efficacy of care interventions.

Recommendation 2:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with the AWI Act code of practice for medical practitioners and that certificates are reviewed when a person is transferred to the ward and that consultation processes with proxies have taken place when practicable and recorded.

Recommendation 3:
Managers must replace the laminate covering on all the single ensuite doors.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also 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. This has been added to the action plan.

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 an individual's care, treatment, and support are 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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