Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 6 November 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

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, Ashcroft 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 February 2024 on an announced visit and made no recommendations.

On the day of this visit, we wanted to follow up on the services plans to establish an activity nurse and to hear about the experience of people receiving care in the ward and to hear from their families, where possible.

Who we met with

We met with, and reviewed the care of six people, two who we met with in person and four who we reviewed the care notes of. We also met with/spoke with four relatives.

We spoke with the locality manager, the senior charge nurse (SCN), the lead nurse, the activity co-ordinator, several members of the nursing team and both consultant psychiatrists.

In addition, we met with an independent advocacy service, ‘Advocacy North-East’.

Commission visitors

Susan Hynes, nursing officer

Tracey Ferguson, social work 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 nine 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 staff were “good” “friendly” and “worked hard”, and that they were “comfortable”. We were told by those that we were able to speak with that they were content in the ward and that staff “looked after” them and were “kind”. They liked having their own room and said the food was “good”.

Feedback from relatives was mixed. Most relatives felt the care and treatment their relative received from the nursing team was excellent and mentioned how staff went “above and beyond” for their family member. They were happy with the input from a range of professionals that ensured their relatives’ physical health needs were met and commented how well looked after and cared for they were.

Some relatives told us that they felt involved in their relative’s care and treatment but did not always feel involved in the decision-making about care or receive regular updates and told us it was difficult to meet with medical staff. Relatives told us that they would know who to approach if they had any issues or concerns and one had been supported to put in a complaint about the service. We spoke to one relative where we received some feedback about small portion sizes and lack of supper/finger food choices. They had also raised concerns about the care their relative had received, which were being investigated by the service. The concerns about portion size and choice of food had also been escalated, and the team agreed there could be more choice provided by the kitchens for supper and there have been discussions about this with the meal provider.

Relatives told us that they could visit the ward at most times of the day and that the staff made them feel very welcomed. All the relatives we spoke to commented about the involvement they had in care plans and feeling they reflected the preferences of their relative.

We received positive feedback from Advocacy North-East who told us they were always welcomed into the ward and staff were supportive of the principles of advocacy. They reported they had not had much involvement in Ashcroft Ward recently. We raised this with the SCN on the day and she will follow up with the service to ensure communication and involvement is re-established on a more regular basis.

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 stressed/distressed behaviours, we saw ward staff responding in a caring and supportive manner, using non-pharmacological interventions, which was positive to see.

When we spoke to nursing staff on the day, we gained a sense that the staff team had a good knowledge and understanding of the people they were caring for and how to support individuals with a diagnosis of dementia. In terms of service development, we were aware that following on from our last visit, though the service had recruited a SCN, they had not remained in the role, and the post was then vacant until July this year. Staff acknowledged there had been a lack of leadership oversight prior to this but all the staff we spoke to reported feeling there was now visible leadership and direction provided by the new SCN and mental health lead nurse. Staff reported enjoying their work and showed commitment to improvement and learning.

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 since our last visit. 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 ward to 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 nursing staff and the consultant psychiatrists recorded all contact with individuals on the electronic system. The weekly MDT meetings were also recorded on this system, along with some nursing assessments, risk assessments and risk management plans. We found most physical health assessments, legal paperwork, nursing care plans and ‘getting to know me’ booklets in the paper files.

We also found completed ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) certificates in the paper files. Where an adult cannot give consent and has a welfare guardian or attorney with the relevant powers in place, the guardian or attorney must be made aware of 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 appropriately.

When we reviewed the daily care records on TRAKCare, we found most of the entries to be detailed, relevant, meaningful, and linked to individuals’ care plans, though in some records there was an emphasis on the physical health needs and care delivered. We discussed this with the SCN who explained the healthcare support workers in the ward had recently started recording in the individuals' notes. The SCN was planning to deliver training in this area, as some seemed to focus on tasks rather than the therapeutic input they were providing.

We witnessed skilful, warm interactions between staff and individuals in the ward with staff spending periods of one-to-one time with them. This was not reflected in the notes, and we discussed with the staff team the importance of recognising, valuing and recording these interventions in the same way as the physical care given.

The paper files we reviewed had detailed 'getting to know me' booklets as well as further information from relatives and carers, which provided information on the individuals' life stories. We saw positive examples where this had been transferred into the individuals' stress and distress and activity care plans, particularly around how to manage stress and distress symptoms, though at times there was a lack of detail about specific interventions. We read in some care plans 'use distraction techniques' without detail of the technique that was effective for the person, while other records provided this level of detail. The care plans all evidenced the use of non-pharmacological interventions as the first line intervention in stressed and distressed behaviour.

All individuals had multiple care plans in place that covered a wide range of needs and most of the care plans were detailed. These showed the involvement of relatives and had been shared with them. Relatives we spoke to commented how they felt the care plans showed how the staff "really understood the person their relative was". We saw evidence of physical health care monitoring throughout the individuals' time in the ward.

We were told that care plans were reviewed weekly. 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, how it was evaluated, if the goals were still relevant and what progress had been made towards attaining these. The lack of relevant review made it difficult to understand which interventions the person responded most positively to, which is important information to record and share with future care providers.

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.

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 heard there were two consultant psychiatrists in 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, speech and language therapy, and occupational therapy. Family members did not attend this meeting; we could not see in the care records reviews where a summary of their views was documented, nor could we find a record of feedback being given to them from the meetings.

The ward continued to have two records of the MDT meeting, one medical note and one nursing; these were kept on the electronic system. On our last visit to the service, we had hoped that moving to an electronic system would address any duplication to allow completion of one record. We were disappointed to find there continued to be two records and in some cases the recording of information was poor with no record of who attended the meeting, sections in the form missed, and no action plan or review of previous actions.

When reviewing the care records, we did not find a consistent approach to the medical review of individuals in the ward and did not see regular records of in-person medical reviews.

Recommendation 2:

Managers must ensure that there is a full discussion at the MDT meeting that records all decision-making with regards to individuals care and treatment, and evidence that the views of individuals and/or their relatives are considered and feedback is given to them.

Recommendation 3:

Managers must review the minimum timescales for in-person medical reviews for all individuals in the ward.

We were told that there were four individuals whose discharge was delayed; they had been assessed as ready for discharge and able to move on. One individual had been waiting for some time, the others were of a shorter duration. 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 Covid-19 pandemic,

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

along with the reduction of inpatient beds at Royal Cornhill Hospital and the closure of Scolty Ward in Banchory.

We had heard of the significant financial pressures on the HSCP which had led to having to apply to two funding streams for agreement to finance nursing home placements. This had caused delays, but we were pleased to hear this process was now more streamlined with one decision-making forum. We were also pleased to hear there was a weekly multi-agency pan-Grampian meeting to discuss any delays to discharge and about the work being undertaken by the HSCP and NHS Grampian on early discharge planning.

We heard this has been positive and was leading to fewer delays for people who were ready for discharge. From discussions with ward-based nursing staff, managers, and families, we heard how everything appeared to be getting done to support discharge, but where there were hold-ups, this was 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 and were keen for their relative to remain in Ashcroft Ward while a suitable local placement was sourced.

We are aware of the pressure on inpatient beds across the Grampian area and that the situation continued to be discussed in the HSCP and with NHS Grampian. We have been told there was a whole system bed-based review underway across all inpatient beds and look forward to hearing the outcome of this.

Use of mental health and incapacity legislation

On the day of our visit, one individual was 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 those 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 the care records.

Where a person had a power of attorney (POA) in place, we found it was recorded in the person’s file if the power of attorney had been activated or not, depending on the person’s assessed capacity. On the day of our visit there were nine individuals who had an active POA. In one case it was not clear that welfare powers were included in the POA, which was raised with the service on the day.

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.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. All 10 individuals had a section 47 certificate in place; one did not evidence consultation with the legal proxy decision maker on the form and one person did not have an accompanying treatment plan detailing which treatments the certificate authorised. Both these issues were raised with medical staff on the day. We were aware that individuals were often transferred to the ward from another hospital and suggested that treatment forms should be reviewed on a weekly basis at the MDT meetings.

For individuals who had covert medication in place, in most cases, all appropriate documentation was in order, with records of treatment plans and reviews, which was in line with NHS Grampian covert medication pathway. In one case the pharmacy advice on method of medication administration was missing from the file, which was raised with the service on the day. The Commission has produced good practice guidance on the use of covert medication.[2]

Rights and restrictions

Ashcroft Ward continued 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 was considered to be at risk of falls and if assistance was required. The staff could use these alarms to help manage individual risk. We heard alarms being activated, and saw staff respond quickly to this. Following our last visit, the locality manager agreed to review the volume of the alarm system that was in place, given individuals with dementia can often experience stress/distress that may be related to noise. The loud alarm system had been addressed, and the volume of the alarms had been reduced. We were pleased to see the difference this had made to the environment.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. There were no individuals who were specified in Ashcroft Ward, nor was any individual requiring continuous intervention.

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[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

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.

When we reviewed the care records we found there was consideration at the MDT meeting around maximising the rights of people who were admitted informally to ensure their continued willingness to remain in the ward.

The Commission has developed *Rights in Mind.*[3] 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

We were aware from our discussion with the service that an activity co-ordinator had been recruited. We were keen to see how this role was functioning in the ward.

We heard from the SCN that group activity could be difficult for some individuals in the ward and there was a focussed piece of work between the activity co-ordinator, key worker, families and the individual, where possible, to explore more individualised approaches to activity provision which would focus on previous interests and skills. We heard the activity co-ordinator supported the nursing team with physical care at specific times of the day but that afternoons should be free for activity provision. We were concerned that this might limit opportunities for activity provision and blur roles.

We saw an activity plan in the lounge area; this was for activities in the main care home area. Though the individuals in Ashcroft Ward could attend this area, staff explained they were mainly unable to attend due to their level of cognitive impairment and the distress that new environments could cause them.

We found activity care plans in each of the records we reviewed, which included details of preferred activities but could not find evidence of these activities being offered. One relative told us that they felt there was a lack of structured activities and events in the ward, while others reported the individualised approach to activity planning suited their relatives and created a calmer atmosphere in the ward.

We had seen reminiscence/rehabilitation and interactive therapy activities (RITA) in other wards in NHS Grampian. This is an all-in-one touch screen system offering digital reminiscence therapy and we saw how this was used by staff to engage

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

individuals in therapeutic activity. We asked if there were any plans for similar systems to be considered in the ward and were told there were approaches being made for funding to 'Friends of Inverurie' and endowment funds.

Recommendation 4:
Managers should ensure that all offers to participate in activities are recorded and all activities undertaken are documented and linked to individual care plans.

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. The dining room was a small space, which with most individuals requiring support with mealtimes, could feel cramped, noisy and busy. Staff told us they managed this by having staggered mealtimes and that some people preferred to have their meals in the lounge area.

On last year's visit, the SCN told us that the plan was to make further changes to the colour of individual doors in the ward area. This was done, and we were told there were further plans to link the decoration in the room to the colour of the person's door. There was personalisation on each bedroom door to support people to identify their own bedroom. We also heard about plans to develop a quiet space at the end of the ward that could be used by visitors and individuals.

Individuals had access to a large, outdoor, dementia-friendly garden where there was ample space for walking and a patio with seating. The 'Friends of Inverurie' had supported the ward with the care of the garden and furnishings in the ward.

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. On our last visit we found that some of this confidential information could be viewed by others, particularly when the door was open. We were pleased to see there had been screening placed over the windows of the doors to maintain confidentiality. We saw an information board for carers and details of advocacy and carer support organisations on the wall at the door of the ward. There was also information about people's rights and about the Mental Welfare Commission visit and services.

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 there is a full discussion at the MDT meeting that records all decision-making with regards to individuals care and treatment, and evidence that the views of individuals and/or their relatives are considered and feedback is given to them.

Recommendation 3:
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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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