Mental Welfare Commission for Scotland

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

Date of visit: 8 February 2018

Where we visited

Brucklay Ward is an older adult assessment unit for people with dementia. It has 12 available beds. On the day of our visit there were 12 patients on the ward. We last visited this service on 14 May 2014 and made recommendations in relation to; care plans being more person centred and regularly reviewed; clarity about medical responsibility for younger patients; and availability of occupational therapy (OT) services.

Following our last visit, we were informed that an audit tool was introduced to monitor record keeping and that care plans would be reviewed quarterly. Also, that there is a procedure agreed to allocate medical responsibility for all patients and that OT input has been clarified.

On the day of this visit we wanted to follow up on the previous recommendations.

Who we met with

We met with two patients and reviewed the care and treatment of a further four patients. We also met with two relatives.

We spoke with the location manager, lead nurse, nurse in charge and other clinical staff.

Commission visitors

Douglas Seath, Nursing Officer

Ian Cairns, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We observed the care and treatment being provided during our visit, and patients appeared to be well looked after. It was difficult to have detailed conversations with many of the patients because of the progression of their dementia. Relatives we met in all three wards also spoke highly about the care and treatment being provided, and the attitudes of staff.

However, though we heard comments from relatives about staff being kind and caring, we also noted that they felt staff did not always keep them well informed. There did not appear to be a named nurse system in operation. Therefore, relatives had to ask for updates and felt awkward about interrupting staff at their work. We heard that staffing levels have been an issue until recently and that this has contributed to the difficulties in keeping up with communications.

Risk assessments and safety plans, reviews of plans, and notes of multi-disciplinary team (MDT) reviews were good and documentation well ordered. Personal recovery plans were detailed and person-centred, and there was clear evidence that they were reviewed on a regular basis. There was also evidence of good physical health care being provided and regularly monitored.

Behavioural charts were completed to help identify any triggers to stressed and distressed behaviour. Care plans followed from this in the form of a safety or recovery plan.

There was OT provision but no input into the activity programme on the ward.

Recommendation 1:

Managers should implement a named nurse system in order to clarify communication channels for relatives.

Use of mental health and incapacity legislation

Each patient file had a status index form detailing any mental health act or adults with incapacity act documentation with review dates. This made it easy to identify formal status and date of authorisation.

S47 certificates of incapacity under Adults with Incapacity (Scotland) Act 2000 (AWI) and covert medication pathways were present, where required, and were authorised using the NHS Grampian specific documentation.

In case files we reviewed, where there was a welfare proxy (guardian or power of attorney) in place, details of this had been recorded and copies of the legal documents obtained.

Where there is no guardian or attorney for a person who cannot consent to a decision about cardio pulmonary resuscitation (CPR), it is a requirement to consult with the close family, as well as trying to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. ‘Do not attempt CPR’ forms were completed with evidence of discussion with nearest relative or proxy as appropriate.

Part 16 (s235-248) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) sets out the conditions under which treatment may be given to detained patients who are either capable, or incapable of consenting to specific treatments. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were all in order as appropriate.

We found oral ‘as required’ medication prescribed in variable doses and we felt that having a specific dosage, and daily maximum, would make the prescription less vulnerable to confusion or medication error. This was corrected on the day of the visit. In addition, where medication was prescribed ‘as required’ in both oral and intra-

muscular routes, the total daily maximum dosage and frequency was not clearly documented in all cases.

There were no issues with identifying medical responsibility for all patients.

Recommendation 2:

Managers should review prescriptions of ‘as required’ medication which should be recorded as specific dosages with frequency of administration and daily maximum dose made clear.

Rights and restrictions

As the patients in the ward all had a diagnosis of dementia, the external fire door to the ward was locked to maintain safety and to prevent patients leaving the ward unnoticed. Individual risk assessments detailed those who may be vulnerable if the door to the ward was open. The fire exit was not locked by a key, but was secured by a magnet, and the staff had the code to open. Alternatively, it could be opened using the green break glass box. Although the door to the ward was locked, this was not causing any undue concerns to patients and the locked door policy was on display for patients and visitors.

Use of bed rail assessments was clearly documented and, where this were not appropriate, falls mats and door sensors were occasionally used to alert staff of patients at risk of falling whilst attempting to get out of bed at night unaided.

Activity and occupation

Concerns were raised by relatives about the level of activities provided and they felt that patients were not encouraged to socialise as much as they could. Nursing staff tried to provide activities and there was a record of participation in activities in each patient’s record. However, we did not find individual activity plans arising from interests detailed in ‘getting to know me’ documents. We heard that there is a plan to appoint an activity nurse in future, and we look forward to seeing this development at our next visit.

We could see that nursing staff were providing care and treatment to people who often have complex needs and significant physical health problems, and that is difficult for nursing staff to undertake planned activities with patients, in addition to clinical duties when staffing is limited.

Recommendation 3:

Managers should take steps to introduce an activity programme and ensure that activities take place wherever possible on a daily basis.

The physical environment

The ward had dementia friendly features with access to a well-designed outside space suitable for patients with cognitive impairment. The ward was well maintained with pictorial signage. Furnishings and décor were of a suitably good standard.

Summary of recommendations

1. Managers should implement a named nurse system in order to clarify communication channels for relatives.

2. Managers should review prescriptions of ‘as required’ medication which should be recorded as specific dosages with frequency of administration, and daily maximum dose, made clear.

3. Managers should take steps to introduce an activity programme and ensure that activities take place wherever possible on a daily basis.

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

Alison Thomson
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 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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