

Mental Welfare Commission for Scotland

Report on unannounced visit to: Ashcroft Ward, Bennachie
View Care Village, Balhalgardy Rise, Inverurie AB51 5DF

Date of visit: 19 February 2018

Where we visited

Ashcroft ward is a 10-bedded dementia assessment ward set within the Bennachie View Care Home and Village on the outskirts of Inverurie. There were six patients in the ward at the time of the visit. Bennachie View comprises a large care home, the ward itself, and a number of small bungalows in a village-type setting. It forms part of a new initiative by Aberdeenshire Integrated Health and Social Care Board to increase its dementia care services. It is still quite new, having opened in 2016.

We last visited this service on 8 April 2016 and made recommendations in relation to life histories being completed consistently, and ensuring that care plans are personalised and reflect and inform the care currently being provided.

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

Who we met with

We met with and/or reviewed the care and treatment of six patients.

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

Commission visitors

Douglas Seath, Nursing Officer

Paula John, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We saw care plans, which were more person-centred, in the file reviews we undertook on the day. Plans were recovery focussed, identified needs and actions, and there was some evidence of evaluation of care plans in continuation notes. However, reviews of care plans did not contain information, simply noting dates when carried out. Multidisciplinary team reviews which we looked at were well recorded and had good descriptions of progress being made in relation to plans of care, and included a record of who had participated in the meetings. There also appeared to be good communication with relatives and welfare proxy, with family meetings arranged prior to discharge plans being finalised. The named nurse system was in use but has come under pressure due to the level of current nurse vacancies.

Where we were able to have meaningful conversations with patients, they were positive about care and treatment provided in the ward.

Life history information was recorded in the files we reviewed, with 'Getting to know me' booklets, completed with help from relatives.

We were pleased to see that a covert medication pathway, taken from the Mental Welfare Commission's good practice guidance, was being used appropriately.

Recommendation 1:

Managers should develop nursing care plans which include more individualised interventions and an evaluation of each intervention when the care plan is reviewed.

Use of mental health and incapacity legislation

Adults with Incapacity (Scotland) Act 2000 (AWI Act) documentation was located in files which were clearly indexed and easy to navigate. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 of the AWI Act legislation, must be completed by a doctor. s47 of the Act authorises medical treatment for people who are unable to give or refuse consent. Under s47, a doctor or other authorised healthcare professional examines the person and issues a certificate of incapacity. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. In Ashcroft ward, s47 certificates authorising treatment were not always on file with appropriate treatment plans. We also found two of the s47 certificates were out of date and needed to be replaced.

Recommendation 2:

Managers should ensure that where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 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.

Rights and restrictions

There is a secure entry to the ward accessed by a doorbell entry system. There is a locked door policy in place. The door is clearly locked as a means of protecting the welfare of patients. Staff reported that there were no issues in respect to unauthorised deprivation of liberty and certainly we did not witness this during our visit. There were assessments of risk of falls recorded in patient files. Alarm sensors in rooms were used to alert staff when patients at risk of falls required assistance to get up to the toilet at night. The performance of the alarms was monitored daily. However, and in spite of this, one sensor was found to be faulty and this had led to a patient sustaining an injury. Staff also found difficulty with the fact that there are alarms with different functions but that they all sound very similar, leading to confusion about the nature of the alert.

Recommendation 3:

Managers should ensure that, in order to protect patients from harm, the faulty alarm is rectified as soon as possible and should consider ways to differentiate the sound of the various alerts.

Activity and occupation

Activities were provided by nursing staff with input from occupational therapy (OT) staff. Although there were activity care plans, nurses often found it difficult to carry these through due to shortages of staff. This is becoming problematic and may affect the ability of the ward to receive new admissions. Staff shortages have been exacerbated by several nursing staff reaching retirement age. Recruitment is ongoing but is difficult in this rural location.

The physical environment

Although the ward was situated on the first floor of the building, it was accessible by a lift which led straight to the front door. The design of the building also ensured that there was access to the garden. Due to the building being on a slope, the large garden at the rear could be accessed on the same level from the dining room. The garden was dementia friendly and had a number of paths, seating areas and raised flower beds. It also had sheltered areas for patients and their families to sit.

All of the bedrooms were large and en suite. There were separate dining and sitting rooms on the ward, with the rooms separated by a corridor. The staff were in favour of the separate spaces. In the space the ward occupied previously, the sitting room and dining area were in the same room which was not ideal. However, this is no longer the case.

The kitchen was also small and doubled up as a space for staff and OT use. Overall however, the facilities were impressive and of a high standard.

Summary of recommendations

1. Managers should develop nursing care plans which include more individualised interventions and an evaluation of each intervention when the care plan is reviewed.
2. Managers should ensure that where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 of the AWI Act must be completed by a doctor.
3. Managers should ensure that, in order to protect patients from harm, the faulty alarm is rectified as soon as possible and should consider ways to differentiate the sound of the various alerts.

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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