



Mental Welfare Commission for Scotland

Report on announced visit to: Elmwood, Bracken Ward,
Ashgrove Road, Aberdeen AB25 3BW

Date of visit: 17 January 2017

Where we visited

Bracken is a 10 bed acute admissions unit which provides assessment and treatment for adults with a learning disability who have a psychiatric illness or present with behaviour which is extremely difficult to manage.

We last visited this service on 29 September 2015 as part of our themed visit programme and made the following observations: there is no record of attendance and non-attendance at activities; carers do not have the opportunity to give feedback or comment on the service; there is need for review of physical health checks forms; and files were bulky and poorly organised making it difficult to locate relevant information.

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

Who we met with

We met with and reviewed the care and treatment of six patients and four relatives.

We spoke with the charge nurse and other nursing staff.

Commission visitors

Douglas Seath, Nursing Officer

Margaret Christie, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Interactions between patients and staff appeared warm, and patients appeared to have a good rapport with the staff, who were engaged with them on the day of our visit. We noted, however, that continuity of care has proved difficult due to the number of registered nurse vacancies in the ward team which need to be filled. It was apparent that staff are doing their best to provide good quality care whilst having to work extra hours and rely on bank staff to provide cover.

The carers we interviewed expressed satisfaction with the care and support being offered to their relatives. However, there were some concerns noted that there are occasions when more vulnerable patients can be at risk from other patients who display physical aggression. Individual risk assessments and plans are in place, but there is a need to consider how best to manage the patient group within the current environment.

Individual files provided evidence that allied health professionals, including speech and language therapy; occupational therapy (OT); and physiotherapy are involved to support a person-centred approach. Weekly ward multidisciplinary team (MDT) meetings are well documented, though attendees are not identified.

Notes and care plans were very easy to navigate. The files were indexed with care plans and risk assessments in place, up to date and subject to regular review. However, the evaluation of care plans would benefit from text in support of conclusions rather than simply entering dates with indication that there had been no change.

Documentation in relation to the Mental Health Act (MHA) and Adults with Incapacity Act (AWI) is in a separate section with all relevant forms included.

Use of effective communication strategies to engage this client group and promote participation was evident. This included 'easy read' versions of documents; pictorial sign boards; and use of scripts to ensure consistency in communication, when relevant for patients.

We were concerned that there did not appear to be an easily identifiable record of annual physical health checks, though staff were sure these were being carried out.

Recommendation 1:

Managers should review the recording of physical health checks to ensure there is consistency of approach.

Recommendation 2:

Evaluation of care plans should be audited by the ward manager to ensure that progress has been measured against care goals.

Use of mental health and incapacity legislation

All relevant copies of documentation under the MHA and AWI Acts were in place with one exception described below. Consent to treatment certificates (T2), certificates authorising treatment (T3) and s47 incapacity certificates were present where indicated, and were of a good standard with treatment plans attached.

Rights and restrictions

Clear guidelines and care plans were in place and regularly reviewed. The use of seclusion is intermittent and only used where indicated and only for so long as is necessary. The accommodation used for this purpose is adequate but not ideal, in that it can impact on the access to some areas of the ward by other patients.

One patient had been made a specified person for use of telephones. Restrictions had continued to be applied in spite of the RES form having expired. This was raised with staff on the day and followed up with the responsible medical officer (RMO).

Recommendation 3:

Managers should keep an index of MHA documentation with dates indicating when reviews are due and introduce regular audit of these.

Activity and occupation

Activity provision is broad in scope, with many patients attending the day centre on site and benefitting from varied provision including arts and crafts, skittles, bowling, puzzles, dog walking and outings. The aims of the activity programmes are to address the development and maintenance of daily living skills; health promotion; social skills development; and creating and maintaining community links. Many activities take place outwith the unit and this promotes continuation of links with the local community.

The physical environment

The decor throughout the ward has been upgraded, and there are adequate furnishings. Many of the individual bedrooms were pleasantly personalised, and patients benefit from single room accommodation. The sitting areas provide the option of public or private space and the ward appears adequate for the current number of patients. However, as previously mentioned, when one end of the ward is used to provide for a seclusion area, this impinges on the available space for other patients. There is an enclosed garden area providing a private space for patients to go outside.

Summary of recommendations

1. Managers should review the recording of physical health checks to ensure there is consistency of approach.
2. Evaluation of care plans should be audited by the ward manager to ensure that progress has been measured against care goals.
3. Managers should keep an index of MHA documentation with dates indicating when reviews are due and introduce regular audit of these.

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.

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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