Mental Welfare Commission for Scotland

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

Date of visit: 11 March 2020

Where we visited

Brucklay Ward is an older adult assessment unit for people with dementia. The ward has 12 beds and on the day of our visit there were eight patients on the ward. We last visited this ward on 8 February 2018 and made recommendations in relation to named nurse system, as required medication, and activities.

On the day of this visit we wanted to meet with patients and follow up on previous recommendations.

Who we met with

Our visit was on this occasion unannounced, so patients, relatives, and staff had no prior warning or notification of our arrival. They did not have the opportunity to plan for contact with, or arrange appointments with us. We met with and/or reviewed the care and treatment of six patients. We did not have the opportunity to meet with carers/relatives on the day.
We spoke with senior charge nurse, location manager and other ward staff, including the activity co-ordinator.

Commission visitors

Tracey Ferguson, Social Work Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We were not able to have detailed conversations with all the patients in the ward, because of the progression of their illness. We were able though to meet and introduce ourselves to a number of patients on the ward and they appeared settled and relaxed in the environment. We observed supportive interactions between nursing staff and patients in the ward during our visit.

We saw detailed nursing assessment documentation in patient files which were completed on admission, along with risk assessments. This document gave a good account of the patient's background and current circumstances. Some files had completed 'Getting to know me' booklets, with help from relatives. We wanted to follow up on our recommendation from our last visit regarding named nurse. We were told that on admission each patient is allocated a named nurse and the named nurse is the point of contact for relatives. We were able to identify from the files we reviewed as to who the named nurse was for each patient.

On reviewing the patient files we saw evidence of good physical health care monitoring. Where covert pathways were in place for medication we saw appropriate paperwork in place, along with good pharmacy input and review. We had a discussion with the manager regarding the importance of ensuring that review dates are always recorded on the covert pathway documentation.

We wanted to follow up on our last recommendation in relation to as required medication. On reviewing the patients medication folder we felt that this has been addressed and that the ward are benefitting from pharmacy input who are regularly reviewing patients prescribed medication.

We saw care plans that were detailed and being reviewed regularly however some care plans lacked details specifically around interventions and were no longer up to date. We brought these to the manager's attention.

As part of patients' mental health recovery plan, the ward has introduced documentation that is being rolled out across NHS Grampian to capture non-medicinal strategies to reduce symptoms of stress and distress behaviours for patients. For each patient files we reviewed, all had this detailed documentation which enabled staff to manage patients stress and distress behaviours. We had a discussion with the manager about how this information could be transferred to patients care plan.

The Commission has published a good practice guide on care plans. 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, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We were told that the ward has access to Allied Health professional (AHPs) or psychological services via a referral system. There are three consultant psychiatrists that cover the ward and we were told that multidisciplinary team (MDT) meetings take place weekly. We saw recordings of MDT minutes in the patient's file; however detail was variable across the files. Although there were actions recorded, some of these were lacking in detail, particularly around discharge planning and outcome of the patients assessment. We had a further discussion with the manager regarding the recording of MDT minutes particularly as the ward currently has five patients that have been identified as delayed discharges. We found further detail in the medical notes of the discussion at the MDT.

The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf).

This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in 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 what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. 'Do not attempt CPR' forms were completed in some files with evidence of discussion with nearest relative or proxy as appropriate, however there were some files that it was unclear if there had been discussions and was not recorded. We were aware that some of the forms had been completed at other hospitals where the patient was previously and therefore advised that a review of the current patients DNACPR should be carried out.

Use of mental health and incapacity legislation

On the day of our visit Mental Health (Scotland) (Care and Treatment) Act 2003 paperwork within the record was easy to access.

For 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 document in the patients file, where we found no copy, and it had been recorded that the person had an appointed person, we brought this to the managers attention.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the Adults with Incapacity (Scotland) 2000 legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We saw that most patients had a S47 completed, however there was a lack of detail and variation in the completion in some of the accompanying treatment plans for patients.

Recommendation 1:

Managers should ensure that treatment plans are completed in accordance with the AWI Code of Practice (3rd edition).

Rights and restrictions

The ward door was secured by a magnet and the staff had the code to open the door.

The ward has a locked door policy in place and we saw individual risk assessments and risk management plans that identified patients who would be at risk if the door were opened. We were told that the ward has good links with the local advocacy service, who visit patients on the ward.

The ward uses a symbol system for patients who have specific mobility needs and each patient had a mobility triangle displayed at their bed which indicated their current mobility status. Falls risk assessments were in place and reviewed regularly.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We wanted to follow up on the recommendation that we made on our last visit around activities. We were pleased to hear that the ward now has a full time activity co-ordinator in place. We heard from the manager that the introduction of an activity co-ordinator has made a huge difference to patient care. We were told that since the introduction of the activity coordinator that the reporting of datix incidents has reduced significantly. The staff team have recognised the benefits of the daily activities to the patients, particularly in managing stress/distress behaviours.

The activity co-ordinator told us that she work four days per week and is flexible in her approach at organising and carrying out activities in groups or on a one-to-one basis. This is a new post so we heard how the co-ordinator is undertaking specific training in order to enhance this role for the benefit of the patients. A weekly timetable of groups activities were displayed on the wall in the ward, which consisted of therapet, balloon throwing, reminiscing, chair exercises, arts and crafts, and music.

We had a discussion with the managers about the recording of activities for each patient to show that these were happening and how the activity benefitted the patient.

The physical environment

The ward has a combination of dormitory and single room bed areas allowing for a degree of flexibility according to patients' needs.

There is an open plan dining/sitting area in the ward which had a door that led out to the large enclosed outdoor garden area. This area was well maintained and had seated areas. The ward was well maintained with furnishings and décor of suitable standard. The manager told us that bedrooms have been recently decorated and now looking at the central corridor design to make the ward as dementia friendly as possible. We were told that there are plans to

introduce further dementia signage around the ward and that occupational therapy is providing expertise in the design area.

Any other comments

The manager told us that staff recruitment can be difficult in the area due to the rural setting. The ward has some staff vacancies that they are continuing to recruit for at present.

Given the patient group, the manager told us that it is not always appropriate to bring in agency staff however this would depend on demand.

Summary of recommendations

1. Managers should ensure that treatment plans are completed in accordance with the AWI Code of Practice (3rd edition).

Service response to recommendations

The Commission requires a response to this recommendation within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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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