Mental Welfare Commission for Scotland

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

Date of visit: 14 September 2023

Where we visited

Brucklay ward is an older adult assessment unit for people with dementia that is based in Fraserburgh Hospital. The ward has 12 beds and on the day of our visit there were 11 patients in the ward. We last visited this ward in May 2022 and made no recommendations.

Who we met with

On the day of the visit, we reviewed the care and treatment of five patients and spoke to four relatives.

We met with the senior charge nurse (SCN), the location manager, and the lead nurse. We also spoke with nursing and ward staff and the activity coordinator. In addition, we liaised with the local advocacy service prior to the visit.

Commission visitors

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support, and participation

During our visit, we introduced ourselves and chatted with all patients in the ward. We were not able to have detailed conversations with all the patients, due to the progression of their illness. From our observations, the ward had a relaxed atmosphere and where there was evidence of stress and distress behaviours, we saw nursing staff responding to the patient in a supportive manner. From speaking to the staff team, we got the sense that they knew the patients well. Some patients told us that they were “happy”, described staff as “lovely” and said that this was a “great place”. Some patients spoke to us about their families and how they enjoyed the visits. Some patients had personal belongings beside their bed to make the space more personalised.

Feedback from relatives was positive, where some described the staff team as “great” “superb” and “very caring”. Relatives told us that they were happy with the care that was provided, and that the communication was good. We heard that they often received regular updates from the nursing staff. Some relatives described the staff team as “experts” in the field of dementia; they felt that the staff team had the necessary skills to manage people with dementia, and always looked at ways to manage distress without resulting in the use of medication. Some relatives were not aware that care plans in place but were happy to receive the updates. All relatives told us that it was the nursing staff who provided the updates and that they very seldom saw or spoke with the consultant psychiatrist.

When speaking with the SCN, they told us that as they managed the community north dementia outreach team, and that good links had been developed between inpatient and community services, providing a benefit in the overall patient experience.

We heard that the dementia outreach team had recruited a mental health and well-being support worker who provided links into the nursing homes across the North Aberdeenshire area. This role was developed to support patients’ discharges, by providing support and training to staff and patients, particularly with approaches to managing stress and distress presentations of patients who had a dementia diagnosis. The SCN told us that since this role had been implemented that there had been no re-admissions. This was positive as we are aware that there can be fewer placements in rural areas, and the investment appears to have helped support individuals to continue to live near their home area and families.

The location manager told us that the ward had recently introduced a twilight shift, and this was due to patients’ needs at this specific time, where stress and distress symptoms of patients was higher.

Care records

We viewed detailed nursing and medical assessments in patients’ files that were completed on admission, along with risk assessments. We also saw a detailed admission entry for each patient in the nursing notes that was completed by the nurse. We were aware that this had been introduced prior to our visit last year, and that the ward staff continued to find this helpful.

We viewed files that had detailed and completed *Getting to know me* booklets, with help from relatives, these provided a life story of the patient's background. We saw positive examples where this information had been transferred into the patient stress and distress care plans and activity care plans, particularly around how to manage stress and distress symptoms.

On reviewing the patients' files, we saw evidence of physical health care monitoring. Where covert pathways were in place for medication we saw appropriate documentation in place, along with ongoing review.

We found do not attempt cardiopulmonary resuscitation (DNACPR) certificates in patients' files that appeared to be in order, except for one, where there had been no discussion with the appointed power of attorney. We brought this to the attention of the SCN.

Most of the care plans we viewed were detailed, however the ward used a template care plan, which meant some of them would have benefitted from being more personalised. The majority of the care plans were reviewed regularly and updated where required. However, the level of detail recorded in the care plan evaluations varied. We brought one patient's care plans to the attention of the SCN, where it appeared there had been no reviews completed within the timescale. As part of a patient's mental health recovery plan, the ward has continued to have a clear focus on the use of non-pharmacological strategies to reduce symptoms of stress and distress behaviours. These were clearly documented in patients' notes, along with evidence of staff following the care plan and applying these interventions, before considering the use of medication. Furthermore, the SCN told us that staff continued to be released to undertake training in relation to the Newcastle Model, which is a person-centred approach to supporting patients who present with stress and distress. This model focuses upon a largely psychological approach, which not only benefits patients, but also their relatives and staff. The model identifies the possible cause for distress, and supportive interventions are put in place to reduce behaviours associated with stress and distress. We noted that it was due to the SCN investment in the staff team that they had the necessary skills, knowledge, and tools to support the patient group.

We found that the daily recordings of the patient notes by staff were detailed and saw how these linked this to the patient's care plans. However, we did see some entries where the use of language was not person-centred and provided no context to the situation. We raised this on the day of the visit and asked about the audits that were in place. We were told that there were regular monthly audits of the documentation carried out, therefore we suggested to the SCN that the use of such language should be addressed via the audits of the notes and during supervision/training sessions.

All patients had a falls assessment and an associated care plan in place, which was reviewed regularly. The ward continued to use a mobility triangle symbol system for patients who had these specific needs, which enabled staff to quickly view the patient's mobility status.

In terms of patients' participation in their care and treatment, all patients on the ward had recorded in their care plans that they were unable to sign due to lack of capacity, however, we found a lack of recording in the files documenting if the relative had been involved or had viewed the care plans. We had a further discussion with the SCN and managers about this, as although we felt that the staff had invested time to involve relatives, they did not always record

the discussions. We consider it to be good practice to record on the care plan if this information had been shared with the relative, noting if they wanted to sign or not, and also to consider incorporating user/relative participation into the monthly audit tool, if this was not already reviewed.

Multidisciplinary team (MDT)

The ward had a locum consultant psychiatrist that covered both the ward, and the community. We were told that MDT meetings continued to take place weekly and usually consisted of the consultant psychiatrist and ward staff. We were told that the ward continued to have access to allied health professionals (AHPs) or psychological services via a referral system, and we saw their involvement evidenced when we reviewed files.

We saw MDT meeting records in patients' notes, with a record of who attended the meeting, along with the actions, outcomes, and also who would feedback to the family. However, the level of detail, along with discussion in the meeting record was variable, particularly where we reviewed episodes of a patient's significant stress or distress in the daily notes. We also found that there was no recorded discussion at the MDT meetings with regards to the consideration of the use of legislation such as the Mental Health (Care and Treatment) (Scotland) Act 2003. There had been several episodes of stress and distress and the need for pharmacological intervention in patients who were not detained under the Mental Health Act.

We had concerns when we reviewed patients' notes as we found that some patients had been in the ward for several weeks and months, however the consultant psychiatrist had not routinely reviewed the patient in person. Reviews and updates in the MDT meeting came via the ward nursing staff, however, we felt there were some patients, where their care and treatment would have benefitted from the wider MDT review and decision-making, especially with regards to the potential suitability of the use of Mental Health Act legislation. We reviewed one patient's care and treatment and we requested that an urgent medical review be carried out.

The ward had input from psychology, and we heard that the psychologist continued to provide training to staff around dementia care and managing stress and distress behaviours.

We were told that the ward currently had three patients who were awaiting care home placements and were reported as having their discharge from hospital delayed. We were advised that there was a weekly meeting with social work representatives from the Health and Social Care Partnership (HSCP) to discuss and receive updates with regards to the progress in discharge planning. We were able to review the record of these joint meetings, however as they were kept in a separate file from the patient notes, we suggested to the SCN that the detail from these discussions needed to be transferred into the patient notes.

Recommendation 1:

Managers must ensure that there is a full discussion at the MDT meeting that records all decision-making with regards to patients care and treatment, along with consideration of legal frameworks to ensure patient rights are maximised.

Recommendation 2:
Managers must review the minimum timescales for in-person medical reviews for all patients in the ward and especially when there have been episodes of stress/distress.

Use of mental health and incapacity legislation

On the day of our visit there were no patients subject to detention under the Mental Health Act.

For patients who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), we saw copies of the legal orders in place.

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. We saw that all patients had a completed s47 certificate, however the completion of some of the certificates was not in accordance with the AWI Act code of practice for medical practitioners. Managers told us that there was a planned audit across Grampian of s47 certificates and treatment plans. We will link in with managers about the outcome of this audit.

On reviewing patients' notes, we were pleased to see that most staff had recorded the specific legal orders that patients were subject to under Adults with Incapacity legislation. This made it clear regarding the legal authority that was in place. We found that there were a few entries that recorded "AWI in place", however these were minimal. Following the Commission's publication of the *Authority to Discharge report* in 2021, the Scottish Government provided funding to develop an Adults with Incapacity framework for staff and this continues to be progressed jointly by the Commission and NHS Education for Scotland (NES). We will continue to keep the HSCPs and NHS Grampian updated of this development as this will promote and support staff to enhance their knowledge base when working and supporting people subject to Adults with Incapacity legislation.

Recommendation 3:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with the AWI Act code of practice for medical practitioners and that these are regularly audited and are discussed and reviewed at the weekly MDT meetings.

Rights and restrictions

The ward continued to operate a locked door, which appeared to be commensurate with the level of risk identified in the patient group. The locked door policy was displayed on the door of the ward.

The ward had good links with the local advocacy service and there was information available on the ward about this service for patients or relatives to access.

Where a patient was subject to continuous intervention, we would expect there to be a care plan in place that was reviewed in line with NHS Grampian policy, however we found that one patient was on continuous observations, and there was no specific care plan in place. We

brought this to the attention of the SCN and they agreed to follow this up. This patient was in the ward on a voluntary basis, not detained under the Mental Health Act.

The SCN told us that the incident reporting system, Datix, was used to record adverse incidents on the ward that involved the patients and also noted where the use of non-pharmacological interventions had provided no benefit to the patient, and where 'as required' medication had been required to be administered. Given that the ward admits patients with a diagnosis of dementia for assessment, we recognised that the staff team were managing a high level of stress and distress behaviours on the ward. We were advised that there were two patients who required significant nursing intervention to reduce the risk of harm to themselves and others, and one patient who required continuous intervention. Managing high levels of stress and distressed behaviours would be expected in a specialist ward, and whilst the level of expertise in this staffing team was high, there are specific times when the application of the Mental Health Act could have been considered, and for this decision to have been clearly recorded.

We reviewed two patients' files where they had recently been subject to detention under the Mental Health Act and found that there had been a decision made that further detention was no longer necessary, however, the detention was allowed to run its course to the end of the 28 day period, as opposed to being revoked when the criteria for detention was no longer met. This resulted in the patients being subject to detention for longer than was deemed necessary. We found another patient whose compulsory treatment order was revoked however, it was unclear if the patient or relevant others knew about this revocation, as there was nothing recorded in the medical file or nursing notes. It was unclear if a mental health officer had been involved or notified in both cases.

Recommendation 4:
Managers must ensure that patients who are detained under the Mental Health Act have regular reviews of their detention status and ensure that where the criteria for detention is no longer met that the detention is revoked and appropriate notifications are completed.

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

The ward had a full-time activity coordinator in place. We heard from the SCN and ward staff of the importance of activities in managing stress and distress symptoms and how the addition of the activity co-ordinator had made a significant difference to patient care over the past few years. It was positive to see and hear how the benefit and focus of activities continued to be recognised in managing stress/distress behaviours in the ward.

Activities were being provided either in groups or on a one-to-one basis, depending on each patient's needs. Some of the activities consisted of therapet, balloon throwing, reminiscing, chair exercises, arts and crafts, jigsaws, and music. We heard how the ward had received a donation and purchased a wheeled television where patients could watch a TV programme

remotely or access applications on the internet to generate discussion during a one-to-one or group session.

We were able to see clear documentation in patients' notes of activities that had taken place and regular review of these with patients. The activity coordinator completed a physical activity level (PAL) for all patients that incorporated a profile linked to the patient's life story which enabled the activities to be tailored to individual needs. We would have liked to have seen more individualised activities for some of the younger patients with dementia who had been admitted to the ward.

The physical environment

The layout of the ward consisted of a combination of dormitories and single en-suite bedrooms, allowing for a degree of flexibility according to the patient's needs in the ward. Each dormitory had a level access bathroom. There was also a separate shower room and bathroom, along with an open plan dining/sitting area in the unit which had a door that led out to the large enclosed outdoor garden area. The garden area was well maintained, and we were told that the garden was a great resource for patients and staff to use. We saw that there had been efforts to maintain the upkeep of the enclosed area and we heard of other future plans.

The ward had received a donation of artwork that was displayed on the walls. The photos had been handpicked and were pictures of all focal points of Fraserburgh. Staff told us that the pictures had enabled conversations with patients, as patients had recognised landmark areas.

There was signage in place to support patients to navigate around the ward and each patient's name was displayed beside the door or above their bed. We suggested other items such as pictures or identification boxes, if patients were at a stage in their illness where they were not able to recognise their name. The SCN told us that this had not been an issue with the current patients, however, we were also told that the different colours of the single bedroom doors helped patients too. We heard that patients were able to bring in some personal items if they chose to and relatives would discuss this with nursing staff.

Summary of recommendations

Recommendation 1:
Managers must ensure that there is a full discussion at the MDT meeting that records all decision-making with regards to patients care and treatment, along with consideration of legal frameworks to ensure patient rights are maximised.

Recommendation 2:
Managers must review the minimum timescales for in-person medical reviews for all patients in the ward and especially when there have been episodes of stress/distress.

Recommendation 3:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with the AWI Act code of practice for medical practitioners and that these are regularly audited and are discussed and reviewed at the weekly MDT meetings.

Recommendation 4:
Managers must ensure that patients who are detained under the Mental Health Act have regular reviews of their detention status and ensure that where the criteria for detention is no longer met that the detention is revoked and appropriate notifications are completed.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication of this report.

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 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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