Mental Welfare Commission for Scotland

Report on announced visit to:
Stracathro Hospital, Willow Unit, Susan Carnegie Centre,
Brechin, DD9 7QA

Date of visit: 19 December 2024

Where we visited

Willow Unit is a 13-bedded unit, situated in Susan Carnegie Centre at Stracathro Hospital, which provides specialised care and treatment for individuals in Angus who have a diagnosis of an organic (dementia) or related illness.

On the day of our visit, there were 12 people in the unit with one vacant bed.

We last visited this service in June 2022 on an unannounced visit and made five recommendations which were when a welfare proxy is in place, a copy of the document stating the powers of the proxy should be held in the case notes, to ensure that where individuals are nursed in a room and prevented from leaving, that there is a clear local policy to support this, that activity care plans are person-centred reflecting the individual's preferences alongside activities specific to their care needs, that a dementia environment assessment be undertaken and the findings from this implemented, and to ensure that outstanding repair and refurbishment work is undertaken as soon as practicable.

On the day of the visit, we wanted to follow up on the previous recommendations and to hear how the service was progressing. We were pleased to see substantial progress with the Commission's previous recommendations. The unit was spotless, and it was clear that extensive refurbishment work had been taken place. We heard that the domestic staff delivered an excellent service in the unit. There was a Tayside policy in place for people when they required to be nursed in their rooms. We saw copies of power of attorney (POA), and welfare guardianship documentation in place, where appropriate. The care plans were person-centred. We were told that the service and the senior management team were working on ensuring activities were recorded in a meaningful way.

We met with three people in person and reviewed the care notes of six people. We also spoke with five relatives.

We spoke with the senior nurse, the senior charge nurse, the charge nurse, nursing staff and domestic staff during our visit to the ward.

Commission visitors

Sandra Rae, social work officer

Gordon McNelis, nursing officer

What people told us and what we found

On the day of our visit, we met with three people who were in the unit but received minimum feedback due to the progression of their illness. Two individuals were able to give limited feedback and another required support from their relative.

The feedback we received was positive, with one person telling us “staff are helpful”. Another person told us “staff do a lot for me”. It was positive to see that the individuals appeared settled, were comfortable in their surroundings and content when interacting with staff.

We spoke with five relatives, either in person or by telephone, to discuss their experience of the care and treatment for their family member while they were in Willow. We had feedback from one relative who told us “Willow Unit is a beacon of how people with Alzheimer’s should be treated”. The relative also spoke of seeing people who were in difficult positions when they come into the unit and because of the person-centred way they are nursed, their progress was quick and they were less distressed.

Other positive comments from relatives were that they felt “fully involved” in their family members’ care. The majority of relatives we met with informed us that they were aware of the care plans for their relative and had regular updates from the senior charge nurse and charge nurse to discuss care plans; there were regular meetings in relation to their family member, which they appreciated and found supportive.

Families discussed the delays in making an application for welfare/financial guardianship to allow them or others to be the legal proxy. They felt this was not fully supported, and their family member was often in hospital for longer than they needed to be. The relatives also understood the boundaries to information sharing and when they were not the legal proxy, there was limited information they could receive at times. They understood the issue of guardianship applications were not directly an issue that the unit were responsible for, but that this was a wider issue with Angus and other areas.

Relatives informed us that there were not many activities planned in the unit, however, staff spent a lot of time with the individuals as they needed expert care, reassurance, and distraction. Relatives informed us the unit staff used techniques like rummage boxes and sensory rooms to support and distract people when they were distressed or needed stimulation.

Care, treatment, support, and participation

Care records

Although all individual care records and care plans were stored on the electronic record system, EMIS, some documentation, such as information around medical treatment, was stored in paper records in the treatment room; this was essential to support treatment being delivered in line with the legal frameworks and to ensure that the rights of the individuals were maintained.

We found EMIS easy to navigate and most continuation notes were informative and linked to care plans.

We saw examples of care plans where the content was comprehensive. These were detailed and there was evidence that they were regularly reviewed. The care plans provided a person-centred, descriptive account of individual needs and subsequent interventions, and we found these linked with the information that was gathered from admission.

Some of the information gathered at the point of admission was sparse; this was due to the limited information that could be gathered when the person, who was cognitively impaired, was admitted to hospital and unable to answer questions that could have made their admission and care smoother from the beginning of their hospital stay.

There was evidence of care plans being regularly reviewed jointly with the individual and family or legal proxy. The ‘getting to know me’ book was completed with the person and family and was a real benefit for staff working with the person and in understanding their needs, likes, dislikes, their social and health history. We were pleased to find the content of care plans gave the reader a good account of the individual’s needs. We found that there were a wide range of person-specific care plans in place that related to both the mental health and physical health of the person.

Risk assessments

We saw risk assessments that were detailed and reviewed regularly. We were pleased to see that occupational therapy (OT) contributed to the risk assessments and treatment plans for individuals. The treatment plans we observed were thorough and focused on a range of areas, including the daily living tasks that individuals could participate in, either independently or with support, so that independence could be maximised.

Discharge planning

Willow Unit had no individuals waiting for discharge when we visited. The unit was forward-thinking and had worked well to highlight people who were likely to require legal powers to be in place; they had progressed this process at an early stage of the individual's hospital stay in order to support them. The unit worked well with Angus health and social care partnership, as well as local advocacy services.

Multidisciplinary team (MDT)
The MDT in Willow Unit had a wide range of professional providing input. The MDT consisted of nursing staff, psychiatrists, a pharmacist, an OT, and part time OT assistant. OT staff completed a pool activity level (PAL) for each person which identified the level of engagement and suitable activities that were then incorporated into the care plans. Activities were then recorded on activity sheets and held on EMIS.

An MDT meeting took place weekly and from reviewing the care records, we were able to see evidence that individuals and their relatives had been included in conversations about their care and treatment, where possible. We noted and were informed that the senior charge nurse or charge nurse contacted relatives and provided feedback after the MDT. This method of communication was supportive for relatives as the needs of person on the ward often plateaued during their stay and there was likely to be limited benefit in them attending the weekly meetings where discussions around the same plan for care would not change substantially.

The MDT sheet contained a nursing review which was robust and in-depth. This gave a summary of the meeting, including clear goals and the management plan for the person. There was also clear information on the mental health legislation that the person was subject to.

Use of mental health and incapacity legislation

On the day of our visit, there were seven patients in the unit detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We found the documentation that related to the individual's legal status to be in order and easily accessible. For individuals who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), we saw copies of these documents in place.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed, although we found multiple copies of a T3 certificate in one file.

When an individual lacked capacity to make decisions about medical treatment, a certificate, along with accompanying treatment plan 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. The doctor must also consult with any appointed legal proxy decision maker, who has relevant powers and record this on the form. We found that while the required s47 certificates were in place, there were also out of date copies stored with the current ones, which was confusing.

Recommendation 1
Managers and medical staff must ensure an audit process is put in place to ensure all documentation relating to the Mental Health Act and the AWI Act, including certificates which authorise treatment and those around capacity to consent to treatment are stored appropriately, with obsolete copies archived.

All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment were stored in the treatment room in paper files.

Rights and restrictions

Willow Unit continues to operate a locked door. This was essential to provide a safe environment appropriate with the level of risk identified for the individuals in the unit. Each person had a locked door care plan that identified the risk factors.

We did not find a locked door policy on display in the unit but noted one outside at the entrance. While this was useful, it was not supportive to those in the locked unit. This was rectified immediately once we brought it to the attention of the senior charge nurse and was in place before we finished our visit. We were pleased to hear that this will be reviewed regularly.

Of the individuals we met with, we found that they had little understanding of their rights, either as a detained or an informal patient, due to their advanced dementia. We were pleased to see that there was regular advocacy support in the ward.

When we visit hospitals, we looked for copies of advance statements. The term ‘advance statement’ refers to written statements made under sections 275 and 276 of the Mental Health Act. These are written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility to promote advance statements. During discussion with staff, we found that people on the ward were no longer able to make decisions regarding their care and treatment. We therefore did not find any advance statements.

When reviewing care records, we saw robust covert medication pathway documentation. This was easy to follow and the rationale for this pathway being in place was clear. The pharmacist was consulted in all cases and their input recorded with care records.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We were pleased to see that Willow Unit had well-designed areas for activities and an area for visitors to meet with their family member out with their bedroom. There was also an open area which had a television where people could sit. We saw the clear benefits of this area during our visit; it enabled those whose mental state was significantly impaired to have the opportunity to watch others and join in with the discussions that were going on. Individuals could spectate and see what was happening and clearly felt included. This area felt calm and was well staffed, which managed the specific needs of some people on the unit. The area also supported discussion and orientation to the day, time, and date.

We saw a room that was used as an activity/sensory/quiet space which was inviting and had modern sensory equipment. We also saw ‘rummage boxes’ which had odd items in them; these helped to start conversations between individuals and the staff in the unit. There was an activity coordinator who visited the ward one day each week and arranged activities. There was also a volunteer who attended every fortnight. We saw evidence of structured activity taking place during our visit.

However, we saw minimal evidence of activities recorded in the daily continuation notes, including what activities individuals were offered and if they participated or declined them. It would have been helpful to have this recorded, as well as any benefit gained by the individual from participation. We highlighted this during our visit feedback meeting and encouraged staff to record the therapeutic activities that they carried out daily.

There was recognition that staff often recorded the care delivered to the person, but did not record the activities they supported the person to take part in.

Recommendation 2

Managers should ensure all activities offered to individuals are recorded in their care records, as well as whether the individual participated or declined. This will encourage the ongoing review and provision of activities that are person-centred for all.

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[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

The physical environment

On the day of our visit, we were impressed with both the layout and cleanliness of the unit. It was warm and inviting and having the open space for individuals to see what was happening on the unit felt homely and inclusive.

The garden was also well maintained and had an easy-to-follow path for walking, with plants that brightened the outdoor space. There had been occasions when vaping was permitted in the garden area and although this was not encouraged, it was still permitted.

Recommendation 3

Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

We found the unit layout welcoming and it had the space for purposeful walking, essential for a unit where all individuals had a diagnosis of dementia or a dementia related illness.

The bedrooms were all ensuite, and the level of cleanliness was excellent. We saw that the unit also catered well for older adults with physical health issues. We were pleased to see a room had been identified for use when someone was significantly unwell and required a level of seclusion where they needed to be nursed in their room. This room was situated in an area of the unit that provided privacy and minimised disruption in the unit.

Summary of recommendations

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Recommendation 2

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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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 an individual's care, treatment, and support are 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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