Mental Welfare Commission for Scotland

Report on announced visit to: Fruin and Katrine Wards, Vale of Leven Hospital, Main Street, Alexandria, G83 0UA

Date of visit: 19 February 2020

Where we visited

Fruin and Katrine wards are mental health assessment and treatment inpatient facilities in West Dunbartonshire, for people over 65 years of age. The wards are co-located on the third floor of Vale of Leven Hospital. Fruin is a 12 bedded facility for patients with dementia. Katrine Ward is a six-bedded unit for patients with functional mental illness. On the day of our visit there were eight patients in Fruin Ward, and four patients in Katrine. We last visited this service on 19 February 2019 and made recommendations relating to care planning, activities, life histories, the use of the mental health act and the environment.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations and also look at communication with relatives.

Who we met with

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

We spoke with the senior charge nurse and members of the nursing staff.

Commission visitors

Mary Hattie, Nursing Officer

Anne Buchanan, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Multidisciplinary team (MDT) meetings are scheduled weekly, and are attended by the consultant psychiatrist, nursing staff, physiotherapist, occupational therapist, and a community psychiatric nurse. Psychology, pharmacy and other allied health professionals, and social work are available on a referral basis and we were told there is a prompt response to referrals. MDT reviews were well documented, with clear actions and outcomes.

We were pleased to hear that the issues with the management and recording of delayed discharges have been resolved since our last visit.

There were positive comments from relatives, both about the care their relatives received and about communication with nursing and medical staff, and the support and consideration they receive as carers.

Ward staff were visible in the ward and engaging with patients throughout our visit. Staff clearly know their patients well and there was a warm, welcoming and calm atmosphere within the ward.

Initial assessments were thorough and contained information on both physical and mental health needs, and detailed information about individuals' routines and likes and dislikes. Risk assessments were up to date.

We found completed getting to know me forms within the files we reviewed. This is a document which records a person's needs, likes and dislikes, personal preferences and background, aimed at helping hospital staff understand more about the person and how best to provide person-centred care during a hospital stay. Life histories were in place, or were being developed. For those patients who will move on to further care placements, it is important that this information is recorded and goes with them through their care journey.

The care plans we looked at were person-centred; there were regular, meaningful reviews and the information gathered in the initial assessment, getting to know me, and life history, were evident in the detail of the care plan. There was evidence of patient and carer involvement in care planning.

Care plans for stress and distress, where these were required, were also person-centred and contained information on early signs of distress, triggers and detailed strategies for distraction and de-escalation.

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

Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health (Care & Treatment) (Scotland) Act 2003 (the 2003 Act), copies of detention paperwork were on file.

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 found completed Section 47 certificates and treatment plans in the notes of the patients we reviewed who lacked capacity. However, whilst it was evident from discussions with relatives and from the chronological notes that proxy decision makers and relatives were being consulted appropriately, this had not been recorded on the section 47 certificate.

Recommendation 1:

Managers should ensure that consultation with the proxy decision maker or relative is recorded on section 47 certificates**.**

Rights and restrictions

Both wards have a key pad system for entering and exiting the ward. There is a locked door policy.

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 wards have an occupational technician who provides activities four days per week. We were advised that she is trained in cognitive stimulation, and provides this and other activities across both wards. During our visit we saw a number of patients in Fruin Ward engaged in a group activity. The activity timetable includes exercise groups, craft groups, reminiscence work, therapet visits, domino sessions which are very popular, weekly sessions with Common Wheel, a music group, and occasional visits from Music In Hospitals and local community groups. The ward is also benefiting from visits from the Football Memories group.

The ward links into local resources, such as Dumbarton football club, and some patients attend events in the local community such as Alzheimer's Scotland tea dances. A local taxi firm provides transport for the patients to attend these and other events at no cost.

Activity is recorded within the patient's files, and there is a clear link between patients previous hobbies and interests and the activities they are participating in.

We heard from relatives that staff take patients out into the community or into the hospital grounds, and encourage and support them to take their relative out where possible.

The physical environment

On our last visit we made recommendations in relation to the clinical nature of the ward environment. We were pleased to see that there have been some changes made in relation to this and to hear that work is ongoing to make the environment more homely. Within the dining room there are now table cloths and battery operated candles on the tables, patients can now have personalised bed covers which help with orientation, and soft toys, including "battery operated breathing cats" which have been found to have a calming effect for some individuals. However relatives commented that there are only fitted wardrobes in the dormitories, there were no bedside lockers, which means they cannot leave any snacks or drinks or small personal items at their relatives' bedside.

We also made a recommendation in relation to access to outside space. Whilst there are limits to what can be done whilst the ward remains on the third floor, we heard that work is underway to develop a dementia friendly garden within the grounds of the hospital, and drawings have been produced for this. We look forward to seeing this in place when we next visit.

Summary of recommendations

1. Managers should ensure that consultation with the proxy decision maker or relative is recorded on section 47 certificates.

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.

MIKE DIAMOND
Executive Director (Social Work)

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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