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: 8 March 2023

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Fruin and Katrine Wards are mental health assessment and treatment in-patient 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; patient numbers are currently capped at eight. Katrine is a six-bedded ward for patients with functional mental illness.

On the day of our visit there were no patients awaiting admission and no delayed discharges. We last visited this service on 30 June 2021 and made a recommendation that managers should review their audit processes to improve the quality of mental health care plans to reflect the holistic care needs of each patient, and identify clear interventions and care goals.

On the day of this visit, we wanted to follow up on the previous recommendation and also to hear how the service had developed and adapted as Covid-19 restrictions had reduced.

Who we met with

We met with, and reviewed the care of seven patients, all of whom we met with in person; we also met with four relatives.

We spoke with the service manager, the senior charge nurse and charge nurse.

Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing officer

What people told us and what we found

All of the patients and relatives that we spoke with were very positive about their experience of care, and complimentary about the staff team. Several commented on the support provided, not just to the patient but also to them as families who were coping with a difficult diagnosis. We heard that communication is "second-to-none". A number of relatives spoke about the welcoming and friendly atmosphere on the ward, and told us that "nothing was too much trouble to the staff". In particular, the senior charge nurse was singled out for their proactive and positive approach with relatives. Throughout the visit, we saw kind and caring interactions between staff and patients. Staff that we spoke to knew the patient group well.

We heard that there is a very stable staff team, with low levels of staff turnover, which we found to be a testament to the leadership of the senior charge nurse. A programme was underway to have all staff undertake refresher training in the management of stress and distress; this was being supported by the psychologist. A number of nursing staff were also undergoing training in venepuncture and undertaking ECG's. One nursing assistant had commenced on an Open University nursing degree programme whilst remaining in the staffing establishment, and hoped to remain on the ward as a registered nurse on completion of their course.

Care, treatment, support and participation

Multi-disciplinary team (MDT)

During our last visit, psychiatry cover was provided by a locum consultant psychiatrist. We heard that the ward now has a permanent consultant psychiatrist. Consultant visits are twice a week and there is a weekly multidisciplinary team (MDT) review meetings. Currently, MDTs are attended by the consultant, junior medical staff, psychologist, nursing staff, physiotherapist, occupational therapist and pharmacist. Social workers attend the ward as required. Relatives were invited to attend reviews. MDT review decisions were recorded on the EMIS electronic record keeping system along with a note of attendees. There was a record of decisions being followed through and action being taken in the chronological notes. Relatives we spoke to were very positive about the availability and quality of communication from both nursing and medical staff.

The ward has dedicated occupational therapy and physiotherapy sessions and dedicated psychology input. The psychologist provides supervision sessions for staff to discuss difficult cases as well as having direct input with patients, particularly around the management of stress and distress. There was access to out-of-hours medical cover from the hospital duty doctor rota. There was good input from allied health professionals. Other services, such as speech and language therapy, were readily available on a referral basis.

Care plans and risk assessments

Initial assessments were detailed and we found completed and informative 'getting to know me' (GTKM), 'what matters to me', and daily routine notes for each patient we saw. These documents contained a significant amount of detailed information, relevant to the individual's comfort and care. Between them, these documents provided information on an individual's needs, likes and dislikes, personal preferences and background, that enabled staff to

understand what was important to the individual, and how best to provide person-centred care whilst they were in hospital. We also found life history books for patients in Fruin Ward.

Risk assessments were reviewed at the MDT and updated thereafter. All of this information was used to compile care plans that were person-centred and had clear care goals. Care plans were reviewed on a regular basis and there were meaningful updates which charted the progress, or otherwise, towards care goals. There was evidence of patient and carer involvement in the care planning process, both initially and during reviews.

Discharge plans were in place for all the patients we saw. Where individuals suffered from stress or distress, Newcastle-type formulations were in place. This framework and process was developed to help nursing and care staff understand and improve their care for people who may present with behaviors that challenge. There were person-centred care plans outlining potential triggers, and management strategies for the individual.

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/node/1203

Use of mental health and incapacity legislation

On the day of our visit, five of the 14 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). All documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act (2000) (AWI), including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date.

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, certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed.

In relation to the AWI, where the patient had granted a power of attorney (POA) or was subject to guardianship, we found information relating to this, which provided contact details for the proxy decision maker. Copies of the powers were available in all the files we reviewed and there was evidence throughout the chronological notes of consultation with proxy decision makers in relation to care and treatment.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI 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 and record this on the form. We found completed forms and records of communication with families and proxy decision makers in all the files we reviewed.

Rights and restrictions

Fruin and Katrine Wards operate a locked door, commensurate with the level of risk identified with the patient group. There was a locked door policy and information on how to access and leave the ward was available.

We heard that since the lifting of Covid-19 restrictions, visiting has now returned to being person-centred, which means there were no set visiting times and no requirement to pre-book visits. However, visitors were routinely limited to two people per patient at any time due to the constraints of space in the ward and to avoid the environment becoming too busy and overstimulating. Visitors were welcome to visit at mealtimes, but were requested to arrive before the meal commences rather than during meal service, to minimise disruption.

The ward had access to advocacy services which was advertised on the ward notice board.

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 has a dedicated occupational therapy technician who provided a range of individual and small group activities; groups such as cognitive stimulation and allsorts groups were provided in conjunction with the psychology assistant. We saw evidence of regular activities being undertaken on a one-to-one and small group basis, both during our visit and in the care plans we reviewed. Each care plan had an activity diary which provided details of the activities undertaken each day. Activities provided were informed by the information in GTKM and led by the patient's choice at the time. We saw evidence in the notes that staff were taking patients outside for walks and accessing the recently opened dementia-friendly garden. We also heard from relatives that nursing staff supported patients to go outside on a regular basis.

We heard that external services had recommenced, including therapet and regular visits from a hairdresser; it was hoped that regular music sessions could be recommenced once funding is established. Outings had only recently recommenced, with a group of patients going out for dinner to a local restaurant the week before our visit. This was well received by those involved and the ward plans to re-establish regular outings to the local community.

We were told that the ward had received its "magic table" activity centre, which we heard about when we last visited. This has proved to be a valuable resource that was enjoyed by both patients and visitors.

The physical environment

The ward was clean and bright; there was dementia friendly signage throughout, and there were murals depicting local scenes around the ward. Fruin Ward is entered via Katrine; both wards had a dining area and separate sitting room, there was an activity room in Katrine Ward.

We noted that in Katrine ward there is a stocked trolley in the lounge/dining area so that patients and visitors could access hot and cold drinks. In Fruin Ward, staff ensured patients'

refreshments were regularly provided. In both wards, tables were fully set at mealtimes with tablecloths etc.

We previously commented on the layout of the ward and the need to provide single room accommodation for reasons of privacy and dignity; the majority of beds in Fruin and Katrine Wards are in communal dormitories, with only one single room in each ward. Despite the limitations of the fabric of the building, staff had been imaginative in their use of colour, plants and art work to make the wards as welcoming, homely and comfortable as possible. We noted that daily newspapers and a range of books and games were readily available for patients.

The ward was on the third floor of the hospital and therefore had no direct access to outdoor space. On our last visit, we saw plans to develop a dementia-friendly garden in the grounds of the hospital and ground work had commenced. We were pleased to see this has now been completed and there was a pleasant, safe garden area which the ward has access to. This has been used regularly and enjoyed by patients and visitors alike. A local mental health community group are involved in the ongoing maintenance of the garden.

Summary of recommendations

The Commission made no recommendations, therefore no response is required.

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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