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: 29 April 2024

Where we visited

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 an eight-bedded facility for individuals with dementia; bed numbers have been capped at eight for several years now and this is unlikely to change whilst the ward remains in its current location. Katrine is a six-bedded ward for individuals with functional mental illness.

On the day of our visit, there were 14 people across the ward and no vacant beds.

We last visited this service in March 2023 on an announced visit and made no recommendations.

There is an ongoing review of older adults' mental health provision across the NHS Greater Glasgow and Clyde (NHS GGC) health board. We were recently advised that this will be going to public consultation in the very near future and the outcome of this will address the issues of accommodation for older adults across the health board in the longer term.

Who we met with

We met with, and reviewed the care of nine people, eight who we met with in person and one who we reviewed the care notes of. We also met with two relatives.

We spoke with the service manager, the senior charge nurse (SCN), the staff grade doctor, and members of the nursing team.

Commission visitors

Mary Hattie, nursing officer

Justin McNicholl, social work officer

Gemma Maguire, social work officer

Paul Macquire, nursing officer

What people told us and what we found

All the relatives and patients who spoke with us were very positive about their experience of care on the ward. We were told that all staff were very proactive in communicating with relatives and that they felt fully involved and informed regarding any care decisions. We heard that medical staff were accessible and responsive to requests for contact. One relative told us of having raised a concern and they were invited to meet with the consultant, the staff grade doctor, and the senior charge nurse the next day to discuss their concern and the issue was resolved.

We were told by everyone we spoke to that they felt welcomed while on the ward, were encouraged to be involved in all aspects of their loved one's care and supported to maintain their relationship. We heard they were able to take their loved ones out or to bring in a meal and have a private visiting space to enjoy dinner together occasionally; we also heard about arrangements that had been made to enable a whole family visit with children and grandchildren. Relatives told us that staff provided support to them as well as their family member and that they felt confident when leaving the ward, knowing their loved one was being well cared for. We heard from patients that they were treated well. One patient told us that the ward had "saved their life" and we heard that staff are "generous in their care."

We heard from staff that there was some anxiety about the introduction of person-centred visiting initially, however this has been fully embraced and staff were very positive about the benefits of this for everyone involved.

Staff and relatives alike remain frustrated by the limitations of the physical environment. We heard that access to the garden is through the day hospital, therefore people have to be escorted by a staff member, which can be difficult when the ward is busy. Having to access Fruin Ward via Katrine means there is a lot of footfall through Katrine Ward, which can be intrusive for people there. We also heard that having only one single room in each ward could be problematic when trying to appropriately meet everyone's clinical needs.

Care, treatment, support and participation

Care records and delivery

Information on each individual's care and treatment was held in three ways; there was a paper file, the electronic record system EMIS, and the electronic medication management system. Care plans and nursing reassessments were held in the paper system. Multidisciplinary team (MDT) reviews and chronological notes were held on EMIS along with paperwork for the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). The health board is in the process of transitioning across to a fully electronic system and we were told that the ward is looking forward to commencing using electronic care plans in May.

Care plans and risk assessments were detailed and we found completed and informative life histories and 'getting to know me', 'what matters to me', and "my day to day" daily routine and preference information for each patient we saw. These documents provided comprehensive information on an individual's needs, likes and dislikes, personal preferences, and background to enable staff to understand what was important to the individual. All of this information was reflected in the person-centred care plans. 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. Where individuals suffered from stress or distress, detailed and informative 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 behaviours that challenge. There were person-centred care plans outlining potential triggers, and management strategies for the individual. This information was being used to deliver truly person-centred care.

We heard from staff that there has been an increase in the clinical activity on the ward with an increase in the level of falls risks and more people experiencing stress and distress. The psychologist, the falls reduction team, physiotherapists, and the violence reduction team had all been involved in looking at this with staff; pinpoint alarms had been introduced and they were investigating the possibility of introducing falls detectors, which linked into the pinpoint system.

Multidisciplinary team (MDT)

We heard that the ward has recently benefited from a new locum consultant psychiatrist who is available and attends the ward several times a week; there is a weekly multidisciplinary team (MDT) review meeting. Currently, MDT meetings are attended by the consultant, junior medical staff, psychologist, nursing staff, physiotherapist, occupational therapist, and pharmacist. The consultant is currently reviewing everyone's medication with the pharmacist and is introducing additional psychological therapies.

Social workers attended the ward as required. Relatives were invited to attend reviews. MDT review decisions were linked to the care plans and recorded on the EMIS electronic record keeping system along with a note of attendees. There was a record of decisions being followed through and the actions that had been taken recorded in the chronological notes.

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.

Use of mental health and incapacity legislation

On the day of our visit, two of the 14 patients in the ward were detained under the Mental Health Act. All documentation relating to the Mental Health Act and Adults with Incapacity (Scotland) Act (2000) (AWI Act), 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 treatment. Certificates authorising treatment (T3) under the Mental Health Act were in place where required.

In relation to the AWI Act, 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 and care plans 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 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 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.

For patients who had covert medication in place, all appropriate documentation was in order.

We found completed 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms for several of the people whose care we reviewed. In some cases, where forms had been completed before the person transferred to Katrine or Fruin Ward, it was not clear whether the proxy decision maker had been consulted in relation to the decision.

Recommendation 1:
Medical staff should review all DNACPRs on admission to the ward to ensure that these are fully completed and communication with proxy decision makers or relatives is documented.

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 saw visitors being welcomed into the ward promptly on their arrival. We did hear from relatives and staff that the location of the ward on the third floor made it difficult for people to get outside.

We heard that person-centred visiting has been fully implemented and was being embraced by staff and visitors. The ward has access to advocacy services that were advertised in several places on the ward. There was also information on display in relation to how to raise concerns or complaints, and information on local carers' organisations.

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.

Activity and occupation

The wards had a dedicated occupational therapy technician who provided a range of individual and small group activities. 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 that provided details of the activities undertaken each day.

The activities that were provided were informed by the information from each individual's life history and their getting to know me form, led by the patient's choice at the time. Doll therapy

had been introduced and there was a large artificial cat, which some people found calming to sit and stroke. We saw evidence in the notes that staff were taking patients outside for walks and accessing the dementia-friendly garden; we heard from relatives that nursing staff supported patients to go outside on a regular basis. We also saw that musical sessions were being provided weekly by the Common Wheel and other musicians who were booked into the calendar. There were regular therapet sessions and visits from a hairdresser. We saw the "magic table" activity centre, which we had heard about when we last visited. This has proved to be a valuable resource for both visitors and patients.

We heard that the SCN has been involved in a short life working group looking at the introduction of activity boxes to support continuous interventions.

The physical environment

The ward was clean and bright; there was dementia friendly signage throughout, and murals around the ward depicting local scenes. Both wards had a dining area and separate sitting room, there was an activity room in Katrine Ward and a quiet room in Fruin Ward where the magic table was located; this was also used by visitors. We noted that in Katrine Ward, there was 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 and artificial flowers were left on the tables. Despite the limitations of the fabric of the building, staff had been creative and thoughtful in their use of colour and artwork, to make the wards as welcoming, homely, and comfortable as possible and to aid orientation. Several bed spaces were personalised with photographs. We noted that daily newspapers and a range of books and games were readily available for patients. A range of relevant health information leaflets and posters providing information on local carers' groups were on display.

There was a pleasant dementia-friendly garden in the grounds of the hospital that the ward could use; this has been used regularly and enjoyed by patients and visitors alike.

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. Fruin Ward has to be accessed via Katrine Ward, which can be intrusive for people there. As the ward is on the third floor of the hospital, with no direct access to outdoor space although there is lift access, we were told that there are occasions when only one lift is working. For these reasons, we do not consider that the ward provides an environment, which meets the needs of the people it serves. We are conscious that the older adult's mental health service review is ongoing and look forward to seeing the conclusions from this with regard to the estate.

Recommendation 2:
The health board should ensure the current review delivers an outcome that addresses the provision of an environment that is fit for purpose and supports staff to meet the complex needs of this patient group.

Summary of recommendations

Recommendation 1:
Medical staff should review all DNACPRs on admission to the ward to ensure that these are fully completed and communication with proxy decision makers or relatives is documented.

Recommendation 2:
The health board should ensure the current review delivers an outcome, which addresses the provision of an environment that is fit for purpose and supports staff to meet the complex needs of this patient group.

Good practice

The focus on obtaining and utilising comprehensive life histories and information on personal preferences and routines, along with the culture of involvement of relatives and the implementation of truly person centred visiting enables the ward team to consistently provide a very high standard of person-centred care for which they should be commended.

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 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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