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: 30 June 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's Routemap (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits, however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out face-to-face.

Fruin and Katrine ward 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; 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 seven patients in Fruin and six in Katrine. There were no patients awaiting admission and no delayed discharges. We last visited this service on 19 February 2020 and made a recommendation that consultation with proxy decision makers be recorded.

On the day of this visit we wanted to follow up on the previous recommendation and also look at the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), care planning and the provision of activities.

Who we met with

We met with and/or reviewed the care and treatment of eight patients and two relatives.

We spoke with the senior charge nurse (SCN), and the physiotherapist.

Commission visitors

Mary Hattie, Nursing Officer

Margo Fyfe, Senior Manager

What people told us and what we found

We heard that during the pandemic, Fruin Ward experienced two significant outbreaks of Covid-19. However, despite staff having to pass through Katrine Ward to access Fruin, there were no outbreaks in Katrine Ward. We were told that management had been very supportive during this period, and that additional medical support from the general hospital and support from the palliative care team had been invaluable.

Care, treatment, support and participation

Consultant cover is currently provided by a long term locum. He visits the ward regularly and holds weekly multidisciplinary team (MDT) review meetings; this continued throughout the pandemic, although in-person attendance was restricted to medical and nursing staff. Currently MDT's are attended by the consultant, junior medical staff, psychologist (this is a new post), nursing staff, physiotherapist, occupational therapist and pharmacist. Social workers have recently recommenced attendance on the ward as required. Relatives attended reviews, pre-pandemic. This has not yet recommenced, but is being actively discussed.

MDT reviews are recorded on the EMIS electronic record keeping system. MDT decisions were clearly recorded. Currently relatives are contacted pre- and post-MDT reviews regarding decisions and copies of notes are sent to them if they wish. Relatives we spoke to were very positive about the availability and quality of communication from both nursing and medical staff.

There is access to medical cover out of hours from the hospital duty doctor rota. This input has continued throughout the pandemic. There is good input from allied health professionals, with dedicated time from physiotherapy and occupational therapy. Other services such as speech and language therapy are readily available on a referral basis. During the pandemic some allied health professional (AHP) services were provided on a virtual basis; however these have all now recommenced on a face to face basis.

Within the care plans we reviewed during this visit risk assessments were documented and reviewed regularly. Care plans were person-centred and addressed risk and mental health needs. However, the quality of care plans varied; for some individuals the mental health care plan attempted to cover too broad a range of needs and issues in one plan. As a result, some of these lacked focus and did not fully reflect the high quality care which was being provided. Mental health care plans would benefit from the inclusion of more detailed information on interventions and treatment goals, which was contained in the chronological notes.

We found that physical health needs were being managed well and this was reflected in the care plans. Care plans for stress and distress, where these were required, were person-centred and contained detailed information on early signs of distress, triggers and clear 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

Recommendation 1:

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.

Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health Act, copies of detention paperwork were on file.

Part 16 (s235-248) 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. We noted that requests for designated medical practitioner reviews had been submitted for the two patients whose treatment required to be authorised under a T3.

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 ('the AWI Act') legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act. We found completed section 47 certificates and treatment plans in the notes of the patients we reviewed who lacked capacity, and consultation with proxy decision makers/relatives was recorded.

Rights and restrictions

Both wards have a keypad entry system, there is a locked door policy and individuals are being supported to leave the ward when they wish too. We heard that advocacy services have not yet recommenced face-to-face visits and continue to provide a telephone/virtual service only.

The current restrictions allow for two designated visitors per patient, visits are booked in advance and we were advised that there are no difficulties in meeting requests for visits. iPads and phones are also available to facilitate contact.

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

We noted that while there was an activity planner on the wall in the activity room, this was geared towards current sporting events and a number of small group activities. The wards have a dedicated occupational therapy technician who provides a range of individual and small group activities. We heard that this service continued throughout the pandemic, ensuring that the provision of recreational and therapeutic activity was maintained. We saw evidence of regular activities being undertaken on a one-to-one and small group basis both during our visit and within the care plans we reviewed. Each care plan had an activity diary which provided details of the activities undertaken each day; this included taking patients outside for walks. We also heard from relatives that patients were supported by nursing staff to go outside on a regular basis.

Prior to the pandemic the ward had close links with the local community and benefited from a range of activities provided by external organisations, including therapet, common wheel (a music group), football memories, tea dances, and attendance at the local football club. A local taxi firm provided free transport to facilitate attendance at external events. Unfortunately it has not been possible to recommence any of these activities yet. However, as restrictions are reduced the SCN will be endeavouring to re-establish community links and reintroduce these activities.

We were told that the ward had been successful in a bid for funding for a “magic table” activity centre, which will be arriving soon. This will be a valuable resource for staff and visitors to use with patients and we look forward to hearing about this and other developments on our next visit.

The physical environment

The ward is clean and bright, there is dementia friendly signage throughout, and there are murals depicting local scenes around the ward. Fruin Ward is entered via Katrine; both wards have a dining area and separate sitting room, there is an activity room in Katrine. The majority of beds are within communal dormitories, with only one single room in each ward. Many wards across NHSGGC have been refurbished to provide patients with individual rooms and we would strongly encourage managers to consider the same here to provide privacy and to protect dignity.

The ward is on the third floor of the hospital and therefore has 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 which the ward would have access to. Unfortunately this has not yet been completed, although we could see initial groundworks have commenced.

Summary of recommendations

1. 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.

Good practice

We were impressed with the level of detail and the quality of information within the chronological nursing notes. These contained detailed information around the individual's mental and emotional state on a daily basis and what may be affecting this. Where individuals exhibited stressed and distressed behaviours, staff clearly put a great deal of thought and effort into identifying actual and potential triggers and provided clear information on effective strategies for distraction and de-escalation. We particularly liked the "Guide to my day" which provided a short, accessible summary of the individual's routine, care needs and preferences.

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.

ALISON THOMSON
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 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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