Mental Welfare Commission for Scotland

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

Date of visit: 11 February 2019

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 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 seven patients in Fruin Ward, and five patients in Katrine Ward.

We last visited this service on 10 October 2017 and made recommendations about access to garden space, dementia-friendly environment, and nutrition.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations, and look at care planning and activity provision.

Who we met with

We met with and/or reviewed the care and treatment of nine patients. We spoke with the senior charge nurse (SCN) and the occupational therapy technician.

Commission visitors

Mary Hattie, Nursing Officer

Mary Leroy Nursing Officer

Anne Buchanan, Nursing Officer

Paul Noyes, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We were told that multidisciplinary team meetings are scheduled weekly, and are attended by the consultant psychiatrist, nursing staff, physiotherapist, occupational therapist, and a community psychiatric nurse. Psychology, other allied health professionals, and social work are available on a referral basis.

The care plans we looked at were not person centred or goal orientated, and did not contain sufficient information on the interventions required to meet the identified need.

We looked at the notes of several patients who experienced stress and distress. The care plans for stress and distress which we saw were not person centred. They did not contain information on the patient's triggers for distress, how this manifested, and what strategies should be used to manage this. We found that, in several of the files we looked at, ABC charts had been completed, giving information on the behaviours which had been exhibited and the antecedents to these, but this information had not been used to inform the care plan.

We looked at the care plans of two patients whose care included the use of a lap strap - in one case to maintain their position in their chair, in another to ensure that the patient had periods resting. In both these care files we found reference to a care plan, and good detail in the chronological notes of when this was used, but there was no rationale setting out the reasons for the use of this restriction, and when, and for how long, this could be used. We referred the SCN to the Commission's guidance on rights, risks and limits to freedom. This can be found at:

www.mwcscot.org.uk/media/125247/rights_risks_2013_edition_web_version.pdf

Within Fruin Ward we looked for life story information within care plans, as this is an important element of person-centred care planning for individuals with dementia. Whilst staff knew their patients well, we did not find life history information recorded in any detail. Some care plans included a completed "getting to know me" document which gave limited information. Other care plans had no information recorded.

We were told that, within Fruin Ward, five of the seven patients' discharges were delayed. Due to changes to the system on which this is recorded, there is no facility for either ward to have delayed discharges formally recorded. The reasons given for the delayed discharges included difficulties in finding appropriate placements, and delays in having a social worker allocated and assessments completed.

Recommendation 1:

Managers should ensure nursing care plans are person centred, containing individualised information, reflecting the care needs of each person, and identifying clear interventions and care goals.

Recommendation 2:

Managers should ensure that, where a patient has a diagnosis of dementia, a comprehensive life history is recorded and used to inform person-centred care.

Recommendation 3:

Managers should ensure that there is a robust system for recording and managing delayed discharges.

Use of mental health and incapacity legislation

There were two patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) on the day of our visit. Detention paperwork was in place, and a T3 (certificate authorising treatment) was in place where this was required.

Where patients had been assessed as lacking capacity to consent to their treatment, there were section 47 certificates, with treatment plans, authorising treatment under

the Adults with Incapacity (Scotland) Act 2000. Where there was a welfare power of attorney in place, there was a record of consultation with them.

Rights and restrictions

Both wards have a key pad system for entering and exiting the ward. There is a locked door policy, and patients who were able to leave the ward safely were able to do so with minimal delay.

During our visit, one patient in Fruin Ward was clearly indicating they wished to leave, but for reasons of safety could not be allowed to do so. We asked for this be reviewed as a matter of urgency.

We found forms within the care plans of several informal patients which indicated that there were restrictions on their freedom to leave the ward. If it is felt necessary to put limits on the time a patient spends outwith the ward and the patient is not detained under the Mental Health Act, this has to be discussed and agreed with them, and they must be advised of their rights as an informal patient.

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/rights-in-mind/

Recommendation 4:

Managers should ensure that where restrictions are placed on patients there is an appropriate legal authority in place to authorise this.

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 ball game. We saw that there was an activity timetable which included exercise groups, craft groups, and reminiscence work. We also heard that the ward had regular Therapet visits, and occasional visits from Music In Hospitals and local community groups.

The ward links into local resources, 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.

On reviewing the care plans of nine patients, we found no activity care plans and very limited recording of activity provision. From the majority of the notes we reviewed, we were unable to find evidence of them having the opportunity to spend time outside the ward.

Recommendation 5:

Managers should ensure that patients have person-centred activity care plans in place, reflecting the individual's preferences and activities to meet their care needs, and that activity participation is recorded and evaluated.

Environment

Both wards were calm and mainly quiet throughout the visit, and appeared clean. However, the wards remain very clinical, with little in the way of furnishings to soften the environment and little personalisation of bed areas. We were advised that, due to Healthcare Acquired Infection regulations, patients were not allowed to have personal items such as their own covers on their beds, and personalisation was restricted to items which could be placed within the memory boxes at each bed area.

We were pleased to see that, since our last visit, contrasting toilet seats have been provided, but unfortunately there has been no progress with provision of access to outside space.

We noted that the white board in the duty rooms in both wards recorded personal patient information that may be seen by other patients and visitors.

Recommendation 6:

Managers should ensure there is a balance between the need to reduce the risk of infection, and the needs of people with dementia to be cared for in an environment that provides comfort and supports orientation to help their recovery.

Recommendation 7:

Managers should ensure that personal information is not recorded where it can be viewed by patients or visitors.

Recommendation 8:

Managers should ensure that patients have easy access to a secure garden space, and all patients have regular opportunities to spend time outside the ward.

Any other comments

Summary of recommendation

1. Managers should ensure nursing care plans are person centred, containing individualised information, reflecting the care needs of each person, and identifying clear interventions and care goals.

2. Managers should ensure that, where a patient has a diagnosis of dementia, a comprehensive life history is recorded and used to inform person-centred care.

3. Managers should ensure that there is a robust system for recording and managing delayed discharges.

4. Managers should ensure that where restrictions are placed on patients there is an appropriate legal authority in place to authorise this.

5. Managers should ensure that patients have person-centred activity care plans in place, reflecting the individual's preferences and activities to meet their care needs, and that activity participation is recorded and evaluated.

6. Managers should ensure there is a balance between the need to reduce the risk of infection, and the needs of people with dementia to be cared for in an environment that provides comfort and supports orientation to help their recovery.

7. Managers should ensure that personal information is not recorded where it can be viewed by patients or visitors.

8. Managers should ensure that patients have easy access to a secure garden space, and all patients have regular opportunities to spend time outside the ward.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

As some of these recommendations were made on our earlier visit in October 2017, we will send this report to senior managers.

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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