Mental Welfare Commission for Scotland

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

Date of visit: 8 April 2026

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Fruin and Katrine Wards are inpatient mental health assessment and treatment 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 ward for individuals with dementia; Katrine is a six-bedded ward for individuals with functional mental illness.

On the day of our visit, there were 12 people across the wards, four of whom were boarding in from other areas. We were told that due to improved patient flow and reduce length of stay in these wards, they now regularly have spare capacity which has been used to accommodate individuals from other areas. This is a significant shift from the previous situation where the ward had to board people out.

On the day of the visit, five individuals' discharges were delayed, mainly due to difficulties in finding suitable placements to meet their needs. Social workers were actively involved in seeking appropriate placements for these individuals.

We last visited this service in April 2024 on an announced basis and made recommendations on do not attempt cardio-pulmonary resuscitation (DNACPR) forms and the environment.

We were told that a process was implemented to ensure DNACPR form were checked and compliant following admission, and that the review of older adult mental health services was ongoing.

Who we met with

We met with, and reviewed the care of six people, five who we met with in person and one who we reviewed the care notes of.

We spoke with the senior charge nurse, the consultant psychiatrist, and members of the nursing team.

Commission visitors

Mary Hattie, nursing officer

Mark Richards, nursing officer

What people told us and what we found

Care, treatment, support, and participation

Individuals we spoke with were positive about the care they received. We were told "staff deserve a medal, they are brilliant, so kind."

We heard about the various quality improvement programmes the ward participates in which include the Milkshake programme, which is designed to address issues of constipation, and the impact this can have on stress and distress. The ward received a commendation for innovation of the year for this project.

We heard that the ward is taking part in a tissue viability project as part of the Scottish Patient Safety Programme.

We were told that the ward has been selected to participate in the Healthcare Improvement Scotland programme addressing the management of stress and distress, and that staff are looking forward to this.

Care records

Information on everyone'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, HePMA.

Since our last visit, care plans and nursing assessments had migrated to EMIS alongside chronological notes, multidisciplinary (MDT) reviews, mental health and adults with incapacity paperwork.

There were completed and informative life histories, including 'getting to know me' (GTKM), 'what matters to me,' and 'my day to day' daily routine and preference information for each person that we saw. These documents were on EMIS and in a paper file to ensure they were easily accessible to any staff who may be unfamiliar with the individual.

These documents provided comprehensive information on an individual's needs, likes and dislikes, personal preferences, and background that enabled staff to understand what was important to the individual. All of this information was reflected in the person-centred care plans.

Care plans and risk assessments were reviewed on a regular basis and there were meaningful updates which charted the person's progress, or otherwise, towards their care goals. There was evidence of individual and carer involvement in the care planning process, both initially and during reviews; discharge plans were in place.

Physical health needs were addressed in the care plans and where individuals suffered from stress or distress, detailed and informative Newcastle-type formulations were in place. This framework and process was developed to help 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 support the delivery of person-centred care.

Multidisciplinary team (MDT)
There is a locum consultant who attends the ward several times a week, along with a junior doctor who attends the ward Monday to Friday; out of hours cover is provided by the duty rota.

There is a weekly MDT review meeting that is attended by the consultant, junior medical staff, psychologist, nursing staff, physiotherapist, occupational therapist, and pharmacist. A planned date of discharge is set for everyone by the MDT shortly after admission. This, alongside good working relationships between the community and inpatient teams has resulted in a significant reduction in average length of stay. Social workers attend the ward as required.

Relatives are invited to attend reviews and where they do not attend, the named nurse liaises with them.

MDT review decisions were linked to the care plans and recorded on the EMIS system, along with a note of attendees. There was a record of decisions being followed through and the actions that had been taken which were documented in the chronological notes.

The ward has dedicated occupational therapy, physiotherapy sessions and dedicated psychology input, which will shortly be augmented by the addition of a psychology assistant who will have sessional input to the wards. 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 good input from other allied health professionals, with other services, such as speech and language therapy who were readily available on a referral basis.

Use of mental health and incapacity legislation

On the day of the visit four people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act and Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment, were in place 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 and authorised all medication that had been prescribed.

In relation to the AWI Act, where the person had granted a power of attorney (POA) or was subject to guardianship, this was indicated on the outside of the person's paper file. We found contact details for the proxy decision maker and copies of the powers in all the files we reviewed. 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 those individuals who required their medication to be given covertly, the appropriate documentation was in order.

We found completed DNACPR forms for several of the people whose care we reviewed. In all these cases it was recorded that proxy decision makers or families had been consulted. We heard from the consultant that following our previous recommendation a checklist had been developed which ensured that DNACPR paperwork, along with other paperwork, was reviewed when an individual was transferred into the ward and any deficiencies addressed.

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.

The ward operates a person-centred visiting policy. Where large family groups wish to visit together or where families wish to celebrate special occasions such as birthdays or anniversaries, the ward activity room could be booked.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any statements in the files we reviewed, however there was information on advance statements on one

of the notice boards in the ward and the senior charge nurse confirmed that this was discussed with individuals during their stay.

The ward has access to advocacy services that were advertised on the ward. There was also information on display in relation to how to raise concerns or complaints, information on local carers' organisations and a 'you said, we did' board.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

The wards occupational therapy technician had retired after many years of service and this post has now been replaced.

The ward continues to provide 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.

Fruin Ward uses doll therapy, and the artificial cat remains popular; these are found to be calming for some individuals. The ward continues to use the 'magic table' activity centre and is about to recommence therapet sessions. We saw evidence in the notes and heard from staff that individuals from both wards go for walks in the local area and there was access to the dementia-friendly garden. There was a visit from alpacas to the ward garden, which was enjoyed by everyone.

Both wards have an activity programme which is amended weekly and the activities provided are led by the individuals' choices at the time. Activities that were provided include music sessions, reminiscence therapy, newspaper groups, quizzes, dominoes, movie nights, nail and hair care, and hand massage sessions.

The physical environment

The atmosphere on the wards was calm, friendly, and welcoming. The environment 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 is an activity room in Katrine Ward and a quiet room in Fruin Ward where the magic table is located; visitors also use these areas. Katrine Ward has a stocked trolley in the lounge/dining area so that individuals and their visitors could access hot and cold drinks. In Fruin Ward, staff ensured refreshments were regularly provided.

In both wards, tables were fully set at mealtimes with tablecloths and other items, along with artificial flowers that 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.

Since our last visit the ward has further developed this, creating a small 'pub' in an area of the main corridor, using murals and wall hangings. We heard people can enjoy sitting having a soft drink or non-alcoholic beer. One of the small rooms of the ward has been repurposed to function as a 'hairdressers salon' and provides a quiet space with a comfortable recliner.

A number of bed spaces were personalised with photographs and bedding or soft furnishings, and a there was a completed 'what matters to me' next to each bed. This contained information which was important to the individual and assisted staff in providing truly person-centred care. Daily newspapers and a range of books were readily available for people. A range of relevant health information leaflets and posters providing details on local carers groups were on display.

There was a pleasant dementia-friendly garden in the grounds of the hospital that could be accessed via the day hospital; people had to be escorted by a staff member, however the garden was well used and staff ensured that individuals who wished time outside could have this.

Having to access Fruin Ward via Katrine means there is a lot of footfall through Katrine, which could be intrusive for the people in Katrine Ward. We also heard that having only one single room in each ward could be problematic when trying to appropriately meet everyone's clinical needs. Staff did tell us that there were benefits of being based in the heart of the community they serve and that this was important to them and to visitors.

We previously commented on the layout of the ward and the need to provide single room accommodation for reasons of privacy and dignity. We are conscious that the older adult's mental health service review is ongoing and look forward to seeing the conclusions from this regarding the estate.

Any other comments

The ward team continues to provide a very high standard of person-centred care and is actively involved in a number of quality improvement programmes. Their enthusiasm and commitment to providing the best quality care should be commended.

Summary of recommendations

For this visit, the Commission did not make any recommendations.

Service response to recommendations

Where required, the Commission requires a response to recommendations within three months of the publication date of this report. Although there were no recommendations made for this visit, 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 an individual's care, treatment, and support are 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.

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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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