Mental Welfare Commission for Scotland

Report on announced visit to: Glenarn Ward, Dumbarton Joint Hospital, Cardross Road, Dumbarton G82 5JA

Date of visit: 30 November 2021

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.

Glenarn is a 12-bedded ward providing care for people with dementia who have continuing behaviour management needs. Admissions are usually from the assessment ward in Vale of Leven Hospital. However, admissions can also be accepted directly from care homes when the patient is known to the service. We last visited this service on 17 April 2018 and made recommendations about proxy decision makers and recording of reviews. There are currently eight patients in the ward.

On the day of this visit we wanted to follow up on the previous recommendations and also look at visiting, activity provision and care planning. This is because of the impact the pandemic has had on the provision of activities and on visiting.

Who we met with

We met with and/or reviewed the care and treatment of six patients and spoke with one relative.

We spoke with the senior charge nurse (SCN), the consultant psychiatrist, the clinical psychologist and the service manager.

Commission visitors

Mary Hattie, Nursing Officer

Kathleen Taylor, Participation and Engagement Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The consultant psychiatrist, pharmacist, psychologist and nursing staff attend the multidisciplinary team (MDT) meeting fortnightly, and the general practitioner (GP) visits the ward Monday to Friday. GP services are available outwith regular visits via the on-call service. There are no dedicated occupational therapy or physiotherapy sessions allocated to the ward, however these services along with dietetics and speech and language therapy are available on a referral basis. The psychologist holds informal drop in sessions for staff to discuss any patient management issues, as well as leading on formulation of care plans for management of stress and distress using the Newcastle model. This is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge.

We heard that patients are automatically discharged from the social work caseload on admission to the unit. Staff told us that there are challenges with social work engagement, with involvement only available when an individual is being considered for discharge. We were told that one situation remains unresolved despite nursing staff contacting social work. We advised the SCN to raise this matter again with social work and asked that they update the Commission on the outcome of this.

Case reviews are held on a six monthly basis and carers are invited to participate in these. Consideration is given as to whether patients still meet the criteria for NHS complex care.

The care plans we reviewed were person-centred, incorporating life history information, and there are regular meaningful reviews. There are detailed care plans for physical and mental health needs and care plans for management of stress and distress, incorporating information on triggers and management strategies. Chronological notes were detailed and it was clear that staff knew their patients and their families very well and were providing truly person-centred care.

Where we found do not attempt cardio-pulmonary resuscitation forms, these had been completed following consultation with carers or proxy decision makers.

The carer we spoke to was very positive about the ward team, the quality of care provided and the level of communication from staff. However, the carer commented that there is not enough staff on the ward and they are always very busy.

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

Recommendation 1:

Managers should engage with their social work peers to ensure that social work input is available when required.

Use of mental health and incapacity legislation

Every patient had a capacity assessment, a section 47 certificate under the Adults with Incapacity (Scotland) Act 200 ('the AWI Act') and treatment plan in place, authorising their treatment. Where patients had a welfare power of attorney in place they were being consulted appropriately.

Where individuals had a power of attorney granted under the AWI Act, this was recorded in the notes, and a copy of the powers were held on file, or there were entries in the chronological notes confirming that a copy had been requested and was being followed up.

At the time of our visit there were no patients subject to detention under the Mental Health (Care and Treatment)(Scotland) Act 2003.

Rights and restrictions

The ward door is locked and entry is via a buzzer or key fob system. There is a locked door policy and information on this is provided to families and other visitors.

We heard that the ward supported visiting as early as possible in line with government guidelines. We found that ward staff recognise the importance of family involvement and supports this wherever possible, including allowing relatives to stay with their loved ones when receiving end of life care. Due to the small number of patients there has never been any difficulties in accommodating all the visit requests received.

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 were told that the ward has been without a recreational therapist for over a year, but that this is recommencing within the next few weeks. This, along with the absence of outside activity providers due to the pandemic has had a significant impact on the patients.

Nursing staff provide activities on an ad hoc basis. Due to the nature of patients' needs most activities are on a one-to-one basis and include hand massage, reminiscence, doll therapy, reading, going for a walk in the garden, or simply having a chat. We saw staff engaging in activities throughout our visit. We heard that the ward continues to try to maintain good links with the local community, despite the impact of the pandemic.

We look forward to seeing the impact of the reintroduction of the recreational therapist on our next visit.

The physical environment

The ward is currently in the process of being redecorated. The colour scheme is bright cheerful and dementia friendly, using colour to highlight doorways, handrails etc. Toilets and signage

are dementia-friendly. The ward corridor usually has pictures of the local area from previous decades, we were told these would be rehung on completion of the painting. The ward has two en-suite single rooms, one double room and two four-bedded dormitory areas. Rooms were personalised with patients having their own bedspreads and family photos on the wall. There are separate dining and sitting rooms, a second quiet sitting room and a sensory room which normally contains a range of sensory equipment, however we were told that the sensory equipment is not currently in use due to concerns about cross contamination during the pandemic. The ward had a warm and friendly atmosphere.

We were very pleased to see that the ward continues to make good use of the dementia-friendly secure garden area with Christmas lights and ornaments around the summer house. We were told that this area has been used to enable visiting to recommence as early as possible.

Any other comments

We were told that the ward currently has five registered nurse vacancies and two individuals on long-term leave. There have been attempts to recruit to vacancies but this has been unsuccessful so far. As a result there are difficulties providing adequate staffing cover, even using bank staff and permanent staff are working additional shifts regularly. We were told that the ward is often staffed with less than a full staff compliment and there is only one registered nurse on duty for the majority of the time. This causes challenges when patients are prescribed controlled drugs, which require two signatures. We found that staff clearly remain committed to providing high quality care under very challenging circumstances and continue to “go the extra mile” for their patients.

Recommendation 2:

Managers should take action to ensure staffing levels are adequate at all times to ensure patient safety and care.

Summary of recommendations

1. Managers should engage with their social work peers to ensure that social work input is available when required.

2. Managers should take action to ensure staffing levels are adequate at all times to ensure patient safety and care.

Service response to recommendations

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

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Suzanne McGuinness
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 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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