Mental Welfare Commission for Scotland

Report on unannounced visit to:

Glenarn Ward, Dumbarton Joint Hospital, Cardross Road, Dumbarton, G82 5JA

Date of visit: 31 May 2023

Where we visited

Glenarn Ward is a 12-bedded ward providing care for people with dementia who have continuing needs in relation to the management of their behaviour. The ward capacity was capped at eight patients on the day of our visit. Admissions are usually from the assessment ward at Vale of Leven District General Hospital; however, admissions are also accepted directly from care homes where the patient is known to the service.

We last visited this service on 30 November 2021, and made recommendations on the engagement with social work to ensure input was available when required, and that action was required to ensure staffing levels are always adequate.

The response we received from the service was that these had been addressed, with a referral pathway in place for social work input, and protocols in place for escalation of staffing issues.

On the day of this visit we wanted to 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 seven patients. As this was an unannounced visit, we were not able to meet with any relatives or carers on the day as there had been no prior knowledge given of the visit.

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

Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing officer

What people told us and what we found

Care, treatment, support, and participation

Multidisciplinary team (MDT)

The ward had fortnightly MDT meetings, attended by the consultant psychiatrist, pharmacist, psychologist, and nursing staff. There was a specialty doctor on the ward from Monday to Friday. GP services were available through an on-call service. There was no dedicated occupational therapy or physiotherapy sessions allocated to the ward, however these services, along with dietetics and speech and language therapy were available on a referral basis.

The psychologist had been providing bite-size stress and distress training sessions on the ward, as well as leading on the formulations of care plans for the management of stress and distress, using the Newcastle model where required. This was 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. The psychologist had planned to deliver two, full-day training courses on stress and distress over the coming months.

We heard that social work input had improved, with two patients who are awaiting discharge having allocated social workers. Case reviews were held on a six-monthly basis, and carers were invited to participate in these. Consideration was given as to whether patients still met the criteria for NHS complex care.

The ward continued to face challenges in relation to registered nursing cover. At the time of our visit, the ward had only four registered nurses, including the senior charge nurse, and the band six charge nurse post was vacant. We heard that gaps in staffing were filled with permanent staff working additional shifts, along with the use of bank and agency staff, and the senior charge nurse working 12-hour shifts and weekends to provide adequate registered cover when required. We were aware that there were difficulties with nurse recruitment across the country, however we were assured that managers were actively working to recruit registered nurses to the service, in order to address this issue. There was a full complement of health care assistants.

Care planning

Information on patients' care and treatment was held in two ways. There was a paper file that contained the care plans, Adults with Incapacity (Scotland) Act 2000 (AWI) paperwork, and some risk assessments. Alongside this, the electronic record system, EMIS, contained all other documentation, including falls and nutrition risk assessments, and MDT reviews chronological notes. We heard that discussions were ongoing with the IT department regarding having all documentation on EMIS.

Despite the staffing challenges that we have highlighted, we were pleased to find that all the care plans we looked at were current, relevant, and evaluated on a monthly basis. There were excellent life histories and completed Getting to Know Me forms for all the patients we reviewed. These, along with the risk assessments, informed the care plans which were holistic and person-centred. We found detailed physical health care plans and care plans for stress and distress, incorporating information on triggers and management strategies. Reviews were

meaningful, and care had been adjusted to reflect changes in the patients' needs and presentation. Chronological notes were relevant and detailed. It was clear that staff knew their patients and their families very well, and were providing truly person-centred care.

Use of mental health and incapacity legislation

None of the patients on the ward were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Where an individual lacked capacity and had a proxy decision maker appointed, either a guardian or power of attorney, this was recorded in their file and a copy of the powers were available.

Where an individual lacked capacity in relation to decisions about medical treatment, a certificate completed under s47 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. It is also good practice to consult with the adult's carers or next of kin if there is no appointed proxy. We found s47 certificates in all the files we reviewed and where this was required. However, whilst we could clearly see evidence of consultation through chronological notes, MDT reviews and covert medication pathways, this had not always been recorded on the s47 form.

For patients who were receiving covert medication there was a completed pathway in place and all appropriate documentation was in order. The Commission has produced good practice guidance on the use of covert medication at:
https://www.mwcscot.org.uk/node/492

Recommendation 1:
Managers should audit documentation to ensure that consultation with proxies or relatives is documented on s47 certificates.

Rights and restrictions

The ward door was locked, and entry was via a buzzer or key fob system. There was a locked door policy, and information on this was provided to families and other visitors. The door to the enclosed garden was open throughout our visit and patients were supported to access this and the garden room should they wish. The ward has an open visiting policy, and this was advertised in the foyer. Information on advocacy services was also available in the foyer.

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

Activity

During our last visit we were told that the vacant recreational therapist post was about to be filled. Unfortunately, this did not happen, and the ward has been without a recreational therapist for two years now. 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 some that were available included 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 and saw evidence of this in the chronological notes. The ward has a range of reminiscence and therapeutic activity equipment, including an old-fashioned radio and typewriter, and a pram. They recently purchased some new activity equipment, including robotic therapy cats, which warm up and purr if stroked. We heard that the ward had continued to maintain good links with the local community; therapet visits had been re-established, and volunteers were once again maintaining the ward garden.

The physical environment

The ward décor was bright, cheerful, and dementia-friendly, using colour to highlight doorways, handrails etc. Toilets and signage were also dementia friendly. The corridor had pictures of the local area from previous decades. We heard that new furniture had just arrived for the ward.

Sleeping accommodation comprised of two en-suite single rooms, one double room, and two four-bedded dormitories. Rooms were personalised, with patients having their own bedspreads and family photos on the wall. There were separate dining and sitting rooms, a second quiet sitting room and a sensory room. The ward had a warm and friendly atmosphere. We were very pleased to hear that any maintenance issues were addressed promptly by the on-site estates department. The ward continued to make good use of the dementia-friendly, secure garden area and the summer house which was furnished with couches and chairs.

Summary of recommendations

Recommendation 1:
Managers should audit documentation to ensure that consultation with proxies or relatives is documented on s47 certificates.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication date of this report.

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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