



mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Glenlee Ward, Midlothian
Community Hospital, 70 Eskbank Road, Dalkeith, EH22 3ND

Date of visit: 18 June 2019

Where we visited

Glenlee is a 20-bedded hospital based complex clinical care (HBCCC) ward for adults over 65. Most patients on the ward have a diagnosis of dementia and can exhibit stressed and distressed behaviours. We last visited the ward on 12 January 2017 and made recommendations regarding care plans, multidisciplinary team (MDT) recording, documentation in regard to the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') and consent to treatment under the AWI Act. The first three recommendations had also been made during the previous visit to the ward in 2015, following which the service provided an action plan to address these.

On the day of this announced visit we wanted to meet with patients and follow up on previous recommendations.

On the day we visited, the ward had 16 inpatients. Two patients were from the East Lothian catchment area, the remainder were from Midlothian. We were advised of ongoing plans for East Lothian patients to transfer back to their area of residence. This is planned when the new inpatient mental health ward for older people opens at Roodlands Hospital in Haddington, due to take place in September 2019.

We also heard about current plans in Midlothian to review mental health services for over-65s. It is thought this will encompass a redesign of inpatient provision in Midlothian Community Hospital with the likely amalgamation of Glenlee and Rossbank Wards. This would reduce inpatient beds from 44 to 20. The details of this proposal are still under review at the present time.

Who we met with

We met with and/or reviewed the care and treatment of nine patients and spoke with three relatives.

We met with the senior charge nurse and deputy charge nurse on the ward and spoke with the activity coordinator and a volunteer on the ward. We discussed our findings with the service manager at the end of the visit.

Commission visitors

Tracey Ferguson, Social Work Officer

Kathleen Taylor, Engagement and Participation Officer

Dr Juliet Brock, Medical Officer

What people told us and what we found

Care, treatment, support and participation

The ward was calm and relatively quiet on the day we visited. The patients we met and observed during the day appeared well looked after. Those who could talk to us about their care spoke of being happy and were positive about the support from staff.

We also received positive feedback from two relatives, who spoke of feeling welcome on the ward, of a high standard of care provided by the team, and reported a good level of communication from both medical and nursing staff. One relative we spoke with was dissatisfied with the journey of their family member's care through inpatient services. This was discussed with the team on the day.

One carer commented that staffing levels on the ward appeared less than expected at times. Both the senior nurses and the service manager confirmed that staffing remained an issue. This was heightened at the time of our visit as both the senior and deputy charge nurse were due to leave their posts. There continued to be a high level of reliance on bank staffing, although we were advised that many bank staff regularly work with the team and know the ward well. A senior nurse told us that staff shortage was the main issue that got in the way of providing quality care (particularly one-to-one time with patients and supporting activities) and that current under-occupancy at 16 beds was favourable in this context. Recruitment and retention of regular staff continues to be a focus for the service.

Multidisciplinary team

At present the MDT consists principally of nursing and medical staff. There is a consultant psychiatrist for East Lothian and Midlothian patients respectively. Junior medical staff on the ward provide day to day physical healthcare and reviews for the patients.

An occupational therapist (OT) and OT assistant offer input to the ward for two sessions per week. Their role is mainly assessment. The ward had a full-time activity coordinator who had recently left, but were advised that interviews were taking place to recruit to this full-time post.

Specialist input from allied healthcare professionals such as a dietetics, physiotherapy and speech and language therapy is arranged on referral.

A senior pharmacist offers weekly input to the ward to check prescribing and audit medication use.

The pharmacist and OT staff do not currently attend the weekly ward round.

Psychology services are based centrally in Edinburgh and there is no psychology input to the ward. Individual referrals can be made for inpatients, but staff advised that lengthy waiting lists prevent this being a realistic option. We were told that the lack of access to psychology, both for individual patients and to support staff training, has been an ongoing concern for around four years.

With regard to staff training, we were told that all ward staff have completed dementia training to skilled level and that most have completed a complex care dementia course. Unfortunately the service have experienced difficulties in accessing stress and distress training. We were advised that although the senior charge nurse was a qualified trainer, they had been unable to utilise these skills due to the absence of psychology supervision.

Recommendation 1:

Managers should review service needs in relation to access to psychology, both for individual patient care and for staff training. Where there are significant unmet needs, this should be addressed at appropriate levels with NHS Lothian.

Documentation

We found that the notes were well organised and easy to navigate, as they had been previously.

Patients' personal histories were well documented in both Getting to Know Me forms and individual activity profiles. The latter were written by the activity co-ordinator, who also provided detailed activity care plans for each patient.

We reviewed care plans, daily progress notes, weekly MDT review notes, and risk assessment information in patient files.

We found that care plans were variable in quality. Some provided a good level of detail and personalisation. However we found many gaps in the provision of care plans for identified needs in individual patients, particularly where these related to physical healthcare (whereas on our last visit, physical health care plans had been of a high standard). Some stress and distress care plans lacked personalisation and meaningful detail; in some instances this appeared to reflect lack of training and specialist knowledge.

Care plans were reviewed monthly, but these reviews often lacked detail and did not involve carers, something we were told the team aspire to do in the future.

MDT review sheets were well completed by nursing staff with patient updates in advance of meetings. The meeting itself was often not documented on these forms and was instead written in the case notes. Our impression was that this sometimes led to lack of documentation of action plans and clear progression from meeting to meeting. If MDT review sheets are not considered fit for purpose, alternative means of documentation should be agreed across the team.

It was disappointing to note that previous action plans to improve and audit both care plans and MDT records had not been happening.

We were told that review meetings involving social work and family were organised when required. The team do not routinely carry out three/six monthly reviews. This could be a missed opportunity for regular holistic reviews with all agencies involved, particularly in relation to discharge planning.

At the time of our visit five patients discharge was delayed.

Recommendation 2:

The ward manager and clinical nurse manager should regularly review and audit all care plans to ensure they are person-centred, individualised, and describe specific interventions, particularly in relation to physical healthcare and the management of behaviour.

Recommendation 3:

We again recommend that managers audit MDT paperwork to ensure this is completed appropriately, in detail and in accordance with the person's needs.

Use of mental health and incapacity legislation

Two patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. Where treatment without consent was required beyond two months, this had been appropriately authorised with a T3 certificate.

We found that documentation for patients who had a welfare proxy under the AWI Act, where a guardian or power of attorney had been appointed, was inconsistent.

Where an individual lacks capacity in relation to decisions about medical treatment, under section 47 of the AWI Act, a certificate must be completed by a doctor. We found s47 certificates present in the files we reviewed, accompanied by individual treatment plans. There were no copies filed with patients' prescription sheets. We consider it good practice that copies are kept with drug prescription sheets to ensure that the professionals prescribing and dispensing medication can easily check the required legal authority is in place to do so.

Recommendation 4:

Managers should ensure consistent documentation of all AWI welfare proxies. Copies of guardianship and power of attorney documents should be accessible, discussed with welfare proxies and the delegation of those powers, as appropriate, should be recorded.

Recommendation 5:

In accordance with good practice, copies of s47 certificates authorising treatment under the AWI Act should be filed alongside patient's drug prescription sheets.

Rights and restrictions

Seven patients on the ward were receiving medication by covert means. All had a covert medication pathway in place and these were appropriately filed alongside the prescription sheets. Of these seven pathways we found that one was unsigned, three were undated and four had no review date. Of the three that recorded a review date, two had not been reviewed within the agreed timescale.

Advocacy support is available on referral from local agencies in both East Lothian and Midlothian.

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.mwscot.org.uk/law-and-rights/rights-mind>

Recommendation 6:

Managers should ensure that where patients are receiving medication covertly, the correct documentation is in place. Regular audits should be carried out to review this, involving the pharmacist as appropriate.

Activity and occupation

The activity co-ordinator who recently left was continuing to provide two weekly sessions to the ward, pending the appointment of their replacement. On the day of our visit the activity co-ordinator and a volunteer were supporting a small group and individuals with activities on the ward.

We were advised that normally an activity programme runs from Monday to Friday, offering both group sessions and individual activities. Individual programmes had been developed in collaboration with OTs, based on life story work with families and the completion of the Pool Activity Level instrument.

Ward-based activities include garden based groups, arts and crafts, music and reminiscence. Ten patients had a Playlist for Life. In addition to ward-based activities, there were opportunities for individual trips out, such as for coffee or local shopping. There is a regular dance at a local miners' club, which patients are supported to attend if they are able, with partners encouraged to join.

Some external organisations provide input to ward activities, including the Cyrenians gardening project, music in hospitals (monthly) and weekly therapy visits. We were told that patients had also enjoyed recent visits to the ward from a therapy alpaca.

There is no scheduled activity provision during evenings or at weekends. Ward staff support informal activities at these times when staffing levels allow.

We noted the open access to both the music/snoozelin room and the activity room (which provides a wide range of games, craft supplies and reminiscence materials). We were told that patients and their relatives are encouraged to access these spaces and freely utilise the materials available during visits.

The physical environment

The ward is spacious, bright and clean. There is good signage and dementia-friendly design, with communal areas providing pictures and interactive boards on the walls, with books and objects of interest displayed on shelving. Some of the paintwork appeared slightly tired and would benefit from refreshing.

The ward provides individual en-suite bedrooms for all patients, located in separate male and female corridors. Rooms are pleasant and patients are able to personalise their space. In each room there is an information board with details about the ward and space for messages to relatives (for example, suggestions of individual items to bring in). Each room has lockable cupboard space. Three of the en-suite shower rooms provide overhead tracking for use of hoists where required. Bedrooms are kept locked during the day, but patients can access their room on request.

It was notable that in addition to the large communal lounge / dining area, a number of rooms have been adapted on the ward to offer patients (and their relatives) other spaces to relax and spend time. These include a comfortably furnished reminiscence room, the activity room and the music/snoozelin room (housing a keyboard and musical instruments as well as sensory equipment). Both these rooms have been adapted from former bedrooms. We were told that all these spaces are kept unlocked and are freely accessible to patients.

A 'pub' room had also recently been opened on the ward, after staff had seen one set up in another dementia ward and had raised funds to install it in Glenlee. The 'Lee Inn' is housed in the former activity room. It is decorated in traditional pub style, with a bar (offering non-alcoholic drinks) and seating around two small tables. A pool table and (soft) dart board are provided, as well as a wall mounted television with a selection of football and racing DVDs. The staff told us this had been a popular addition in the six weeks since opening, with patients and relatives using it daily as a place to sit and spend time together.

The ward has an enclosed garden area, accessed directly from the lounge. This is a visually interesting and welcoming outdoor space. The garden was developed with the assistance of Health Foundation funding. Around a circular path, surrounded by colourful planting, are several seating areas and a gazebo. Growing in the raised beds, which Cyrenians volunteers help patients and staff to maintain, were plants, vegetables and soft fruit. Additional interest was provided by bird boxes, feeders a bird bath and raised sandpit. The windows of a public corridor overlooking one side the garden had been screened off using an adhesive landscape motif. This thoughtful addition provided both privacy for patients and a visual panorama within the garden itself.

Any other comments

Information leaflets for relatives are provided on admission and staff told us they tried to meet with families regularly. Visiting times are flexible and families are encouraged to help with mealtimes where appropriate. We asked about carer support. Staff told us that a support group had previously run for several years, but that attempts to re-establish this had been unsuccessful. The team hoped to revisit this.

Summary of recommendations

1. Managers should review service needs in relation to access to psychology, both for individual patient care and for staff training. Where there are significant unmet needs, this should be addressed at appropriate levels with NHS Lothian.

2. The ward manager and clinical nurse manager should regularly review and audit all care plans to ensure they are person-centred, individualised, and describe specific interventions, particularly in relation to physical healthcare and the management of behaviour.
3. We again recommend that managers audit MDT paperwork to ensure this is completed appropriately, in detail and in accordance with the person's needs.
4. Managers should ensure consistent documentation of all AWI welfare proxies. Copies of guardianship and power of attorney documents should be accessible, discussed with welfare proxies and the delegation of those powers, as appropriate, should be recorded.
5. In accordance with good practice, copies of s47 certificates authorising treatment under the AWI Act should be filed alongside patient's drug prescription sheets.
6. Managers should ensure that where patients are receiving medication covertly, the correct documentation is in place. Regular audits should be carried out to review this, involving the pharmacist as appropriate.

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.

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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