Mental Welfare Commission for Scotland

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

Date of visit: 9 April 2025

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

Glenarn Ward is a 12-bedded ward providing care for people with dementia and who have continuing needs related to behaviours that can challenge. The ward capacity has been capped at eight patients for some years now and we are advised this is likely to be permanent. Admissions are usually from the assessment ward at Vale of Leven District General Hospital, although admissions are also accepted directly from care homes where the individual was known to the service previously. Glenarn Ward forms part of the older adult's mental health service for West Dunbartonshire.

On the day of our visit, there were no vacant beds.

We last visited this service in May 2023 on an unannounced visit and made recommendations on the need to consult with proxy decision makers.

On the day of this visit, we wanted to follow up on the previous recommendations and look at how the service has developed over the last two years.

Who we met with

We met with, and reviewed the care of five people, four who we met with in person and one whose care notes we reviewed. We also met with four relatives.

We spoke with the service manager, the senior charge nurse (SCN), and members of the nursing team.

Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing officer

Catriona Neil, medical officer

What people told us and what we found

The relatives we met with were all positive about the care provided. Comments we heard included “since mum was admitted I can sleep at night knowing she is safe here. I trust the staff implicitly; they know her so well.” “Staff are second to none, they all have such compassion and patience”; “Staff are lovely, you always feel welcome, and the senior charge nurse is so approachable and easy to talk to.”

We heard about a recent increase in the social activities in the ward, including people getting out into the community to attend church, or events in local organisations they were previously involved with. We were told that several individuals had new wheelchairs that allowed them to access the community or the hospital grounds.

We also heard that there were ongoing problems with clothes going missing in the offsite laundry, despite them being marked. This was discussed with staff during the visit.

Care, treatment, support, and participation

Care records

Information on care and treatment is held in on the electronic record system EMIS and the electronic medication management system HEPMA. There were also paper files, containing Power of Attorney (PoA) or guardianship documentation, section 47 certificates, Do Not Attempt Cardiopulmonary Resuscitation forms (DNACPR), ‘Getting to know me’ (GTKM) and life story information.

Care plans and risk assessments were detailed and we found completed and informative GTKM and life story information for each person we saw. These documents provided information on an individual’s needs, likes and dislikes, personal preferences, and background that enabled staff to understand what was important to the individual.

This information was reflected in the person-centred care plans. Care plans were reviewed on a regular basis and there were meaningful updates. Where individuals suffered from stress or distress, detailed and informative Newcastle-type formulations were in place, and these was being used to inform the care plan and deliver person-centred care. This framework and process was developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge. Chronological notes were relevant and meaningful.

Multidisciplinary team (MDT)

MDTs are held weekly, and attended by consultant psychiatrist, local GP and nursing staff, pharmacist and psychology attend on request depending on need. MDT review decisions were recorded on the EMIS electronic record keeping system along with a note of attendees. Case reviews are held six monthly and consideration is given as

to whether individuals still met the criteria for NHS complex care. Relatives are invited to reviews.

Currently there are two individuals whose discharge from hospital is delayed while appropriate care home placements are being identified.

GP services were available through an on-call service, and we heard that they were very proactive in consulting with proxy decision makers. The ward has dedicated psychology input and this is particularly helpful around the management of stress and distress. There is no dedicated occupational therapy or physiotherapy sessions allocated to the ward although these services, along with dietetics and speech and language therapy were available on a referral basis.

On our last visit we heard that there was a high vacancy level in the nursing team. This has since been rectified and the ward is now fully staffed. All the newly qualified registered nurses are provided with a one-year training programme while other ongoing training includes management of stress and distress and end of life care.

Use of mental health and incapacity legislation

On the day of the visit no-one was detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003.

All the individuals in the ward were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

All documentation relating to the AWI Act was in place. 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 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. It is also good practice to consult with the individual's carers or next of kin if there is no appointed proxy. We found s47 certificates in all the files we reviewed. However, while we could clearly see evidence of consultation through chronological notes, MDT reviews, covert medication pathways, and in our discussions with relatives, this had not always been recorded on the s47 form.

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

For the individuals who were receiving covert medication, there was a completed pathway in place and all appropriate documentation was in order.

Rights and restrictions

Commensurate with the level of risk identified in the patient group, 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 ward operates person-centred visiting. We heard from one relative how flexible this was and how important it was to them and their relative. The ward has an enclosed garden that people were encouraged and supported to use.

Information on visiting, advocacy services and local carers' services was available in the foyer.

The Commission has developed *Rights in Mind.*[1] 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 activity co-ordinator post has been vacant for over two years now. However, we heard from relatives about the significant increase in activities happening in the ward in recent months. We also found evidence of this in the notes we reviewed.

We heard from the SCN that while there is no dedicated activity co-ordinator, activities are seen as a priority and this responsibility is shared by all the staff. Some of the health care assistants have particular skills in this area, with one individual regularly undertaking small group quiz and games sessions and another providing pamper sessions, including hand and head massage.

There are monthly sessions with a singer. OT has started a weekly 'all sorts' group. This involves cognitive stimulation and sensory activities. We heard about the positive impact of this for individuals, families and staff. OT are monitoring the outcomes of this group which is currently delivered in four-week blocks. Nursing staff have been continuing to deliver the group in between these dedicated blocks.

We heard that relatives are actively encouraged to participate in the activities being provided and several people are being supported to have time off the ward to attend events in the community as well as going for walks in the grounds and outings to local shops.

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Physiotherapy provides support to relatives where needed, to ensure they have the confidence and skills to enable them to take their loved one out and another individual had been able to have time in their own home with their family.

Staff are keen to further extend the activity provision to include a wider range of meaningful daily activities in the ward.

The physical environment

Sleeping accommodation comprised of two en-suite single rooms, one double room, and two four-bedded dormitories. Rooms were personalised, with people having their own bedspreads and family photos on the wall.

There were separate dining and sitting rooms and a sensory room. However, we did note that the ward décor has become noticeably tired, with a number of walls being scuffed and the paint chipped. There was also staining on the ceiling because of water ingress.

Recommendation 2:
Managers should review the ward décor and arrange repainting where required.

The ward continues to make good use of the garden area and the summer house, however, these areas need attention. The fence was blown down in January this year and the summer house was damaged. These have not yet been repaired, meaning the garden area is not safe to use without direct staff supervision. The paths and flower beds are overgrown and in need of attention to ensure this area is safe and dementia friendly.

Recommendation 3:
Managers should consult with estates to address the remedial work needed to provide a safe and pleasant garden area.

Any other comments

We heard from relatives and staff that there were ongoing issues with clothing going missing when sent to the offsite laundry, despite this being clearly marked.

Recommendation 4:
Management should take action to address the deficiencies in the laundry system leading to clothing loss.

Summary of recommendations

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

Recommendation 2:
Managers should review the ward décor and arrange repainting where required.

Recommendation 3:
Managers should consult with estates to address the remedial work needed to provide a safe and pleasant garden area.

Recommendation 4:
Management should take action to address the deficiencies in the laundry system leading to clothing loss.

Service response to recommendations

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

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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