Mental Welfare Commission for Scotland

Report on announced visit to: Brandon and Clyde Wards, Udston Hospital, Farm Road Burnbank, Hamilton ML3 9LA

Date of visit: 16 November 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government Covid-19 guidance. There have been periods during the pandemic where we have been unable to conduct our face-to-face visits and have carried out virtual visits; however, this local visit was able to be carried out face-to-face.

Brandon Ward is a 20-bedded, mixed sex admission and assessment for patients over 65 years with dementia. At the time of our visit there were nine patients on Brandon ward, four of whom were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

We last visited this service on 23 January 2020. On the day of the visit we wanted to follow up on previous recommendations regarding nursing care plan reviews and prescribing of 'as required' medication.

Clyde Ward is a 20-bedded, mixed sex admission and assessment for patients over 65 years with a functional illness. At the time of our visit there were 11 patients on Clyde Ward, five of whom were subject to the Mental Health Act.

We last visited this service on 4 February 2021. However due to the Covid-19 pandemic, we were unable to conduct our visit face-to-face, and conducted a virtual visit to Clyde Ward. On the day of this visit we wanted to follow up on a previous recommendation, regarding patient access to telephones to ensure that they had were able to contact their relatives, during times of restricted visiting to hospitals.

Who we met with

On Brandon Ward we met and reviewed the care and treatment of six patients and one relative.

On Clyde Ward we met and reviewed the care and treatment of six patients, and had telephone contact with two relatives.

We spoke with the service manager, the charge nurses and the lead nurse. In addition we met the wider team for both services. This included consultant psychiatrist, psychologist, occupational therapist, delayed discharge coordinator, and social worker.

Commission visitors

Mary Leroy, Nursing Officer

Yvonne Bennett, Social Work Officer

Kathleen Taylor, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

For both wards patient documentation is held on the electronic system MIDIS, with legal documentation held in a paper lite folder. We were told that both wards will migrate to a new electronic recording system "Morse"; the services have commenced setting dates for training in this new system.

When we spoke with the staff on the wards it was evident that they knew the patients well and delivered person centred care. On the day of our visit both wards were busy but calm. We noted patients appeared comfortable in the company of staff. While it was not possible to have detailed conversations with many of the patients on the wards, we did hear some positive comments on the care and support provided by the clinical team.

We were pleased to see the detail of information in progress notes. We saw good evidence of engagement with families in the chronological notes, and on Brandon Ward we noted a care plan that focussed on family communication.

We were able to meet with one relative on the day of the visit, and spoke to two relatives by telephone. The relatives we spoke to, were complimentary about staff within the clinical team. They told us they were confident that their loved ones were receiving good care and staff were friendly and approachable. We heard that they were patient in manner and spent time chatting and knew their patients well. The relatives we spoke to told us they were consulted by staff in relation to treatment decisions and contacted if there were any concerns

We were pleased to see the continuing development of the nursing care plans in both services. All the nursing care plans we reviewed were person centred and an accurate reflection of the care delivered. They were dynamic with good links to the outcomes from the multidisciplinary team meetings.

On our last visit to Brandon Ward we made a recommendation regarding nursing care plan reviews. We were pleased to see the reviews were thoughtful and meaningful, and detailed progress and changes in patient care.

We discussed and noted involvement of psychology in supporting the care and treatment of patients with complex needs. The psychologist leads on the development of formulations to support the complex care needs for some patients. Plans which detailed how staff would support a patient who became stressed or distressed were particularly clear and comprehensive.

In Clyde Ward there had been focus on the Roper-Logan and Tierney model of nursing. This is a theory of nursing care based on activities of daily living, this model underpins the nursing care plans. In the chronological notes the team has focussed on the recording of subjective and objective view of care, this approach focuses on the patient's view of their care and also evidences good patient involvement.

On discussing psychology input to Clyde Ward, the current focus is on supporting the care and treatment of patients with complex needs; the service is focussing specifically on behavioural

activation, which is an evidence based treatment for depression. Psychology input also involves supporting the wider clinical team through education and training in the specific therapeutic interventions delivered.

Risk assessments on both wards were robust and regularly reviewed.

The documentation for multidisciplinary team (MDT) meetings is detailed and provides a good record. The MDT meetings are held weekly. Families and patients are invited to attend the MDT meeting. The clinical decisions that occur during these meetings are clearly documented and generate an action plan with outcomes and treatment goals. Within both wards there is evidence of a multidisciplinary approach to care. In attendance at the MDT meeting there is medical staff, nursing, occupational therapy, and psychology input.

The meeting is also attended regularly by the delayed discharge coordinator and a ward based social worker. The senior charge nurses recognises that this support is instrumental in ensuring that discharge for the patient is identified early, ensuring assessment and discharge is planned for, and in collaboration with the patient family and the clinical team.

We did note that discharge planning notes are held together for all patients as an overview of all the discharge activity within the ward. We heard how this document allows the clinical team to overview all delayed and planned discharges that are pending. We discussed the benefit of an individualised discharge care plan being held on the patient's individual file.

We were told that if required: physiotherapy, dietetics and palliative care were available on a referral basis.

Food

On the day of our visit concerns were raised by patients about the quality of food being offered on the wards. We note that this issue has been raised on previous visits to the service, and it appears that this matter remains ongoing.

Issues raised related to poor choices of meals, the quality of the food is poor, and it lacks flavour and nutritional value. We discussed this with the service manager who will raise this with the catering manager.

Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') copies of detention paperwork were on file.

Part 16 (s235-248) 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 treatments. Certificates authorising treatment (T2/3) under the Mental Health Act were in place where required and authorised all treatment prescribed.

We found Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in the patient files we viewed; Covid-19 anticipatory care plans were also in place. We saw confirmation of the involvement of relatives in decision making in relation to these documents

Where patients have a proxy decision maker appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), this was recorded in the care file and in all the files we reviewed the certificate granting the Power Of Attorney was on file; however, we found in one file there was no copy of the powers. The SCN was able to locate them and filed them appropriately ensuring they were accessible to all staff who were delivering the care and treatment to the patient.

Where individuals are deemed to lack capacity to make decisions about their health care, section 47 certificates are required; the s47 certificate authorises treatment under the Adults with Incapacity (Scotland) Act 2000. We noted for two patients in Brandon ward, although the s47 certificate was in place, the proxy decision maker was not consulted with, and the appropriate section of the document was not signed.

We raised this matter with the SCN on the day of the visit. We saw that copies of s47 certificates were generally kept in the individual patient's paper lite files, and were not stored with the individual patient's medication chart. We would suggest a copy of the s47 certificate should be kept with the medication chart, which makes it clear to anyone administering medication what specific treatment(s) is authorised by the s47 certificate.

Recommendation 1:

Managers should ensure that treatment plans for section 47 AWI Act certificates are discussed with the welfare proxy. Managers should ensure the certificates are kept with the prescription records for ease of access and to ensure that anyone administering medication is fully informed of treatments authorised through the s47 certificate.

Rights and restrictions

We were told that advocacy input is available on request and that the patients who use this find it valuable and supportive.

A significant issue across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting. During lockdown the wards have utilised technology to ensure links with key people were maintained. The use of technology has been a positive addition to the range of ways patients can maintain contact with important individuals in their lives. We were pleased to hear that face to face visiting has resumed in line with guidance from Scottish Government.

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

On the day of the visit we discussed the role of the activity nurse and the use of the Pool Activity Level (PAL), which is an instrument used to support intervention planning for people with cognitive impairment. We noted there was good evidence of activity provision within the

ward. The patients are individually, assessed initially using their life history profile. Following this assessment, an individual activity action plan is devised based on the person's individual needs, which ensures the individual is engaging in a range of meaningful activity. The activities that the individuals participates in are varied.

In Brandon Ward we noted that each activity session was documented, and if the patient had not engaged this was also recorded. However, we did note that there was little information on the activity session and also the levels of engagement from the patient.

In Clyde Ward, again there was some basic recording of activity, and also a rating scale on engagement. However there was again very little information on what the activity was, and how the patient engaged and participated.

On the day of the visit we discussed with the senior charge nurses on how both wards could continue to develop the recording of activity in a way that evidences the patient's involvement and engagement in the activity. We look forward to seeing this model being embedded further in practice.

The physical environment

The SCN in Clyde Ward described the physical environment of the ward as "not fit for purpose". There appears to be ongoing concerns about the fabric of the wards and questions raised by the staff about the current environment and whether it will continue to meet the needs of the patients in the future. There have been recent comments from student nurses on placement regarding the poor environment.

The flooring throughout the ward is not dementia friendly, the surfaces are shiny, which is problematic for some patients. The ward is awaiting new soft furnishing. There is a combination of single rooms and dormitories. Although we note there is a decorative maintenance programme in place, the ward appears dark and some areas in need of redecoration and refurbishment.

Brandon Ward has clear dementia-friendly signage in place. Paintwork and flooring is also dementia-friendly. The ward has a large main communal area, a conservatory, and another large communal area for activity and visitors to use.

We heard that there are ongoing discussions around the use of the space within the ward. In particular the need for family space so that when families wish to remain with patients at end stage palliative care, there is a room that families can use. The development of this space is part of the ongoing renovation and refurbishment programme.

There is a dementia-friendly enclosed garden. This is accessed from via doors in the conservatory. This space is shared and used by both wards.

Recommendation 2:

Managers should undertake a complete environmental audit and develop an action plan to deliver an environment within Clyde Ward that is fit for purpose and supports staff to meet the complex needs of this patient group.

Summary of recommendations

1. Managers should ensure that treatment plans for section 47 AWI Act certificates are discussed with the welfare proxy. Managers should ensure the certificates are kept with the prescription records for ease of access and to ensure that anyone administering medication is fully informed of treatments authorised through the s47 certificate.

2. Managers should undertake a complete environmental audit and develop an action plan to deliver an environment within Clyde ward that is fit for purpose and supports staff to meet the complex needs of this patient group.

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 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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