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: 25 May 2023

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 announced visit was carried out face-to-face.

Brandon Ward is a 20-bedded, mixed-sex admission and assessment unit for patients over 65 years old with dementia; at the time of our visit there were seven patients on Brandon Ward. Clyde Ward is a 23-bedded, mixed-sex admission and assessment unit for patients over 65 years with a functional illness; at the time of our visit there were 13 patients on Clyde Ward. We last visited both services on 16 November 2021.

For this visit, we wanted to follow up on previous recommendations regarding section 47 treatment plans being discussed with proxy decision makers and upgrading the environment, particularly in Clyde Ward.

Who we met with

We met with and or reviewed the care and treatment of six patients and spoke with two relatives.

We spoke with the service manager, the senior charge nurses and charge nurses from both wards.

Commission visitors

Anne Craig, social work officer

Justin McNicholl, social work officer

Mary Leroy, nursing officer

What people told us and what we found

Care, treatment, support and participation

Care and treatment

All patients we spoke to had only praise for the staff team. One family described the care given to their loved one as “heartfelt” and delivered with kindness and dignity. They also wanted to highlight their gratitude to the nursing staff in Brandon ward, saying they were “phenomenal”. Another patient in Clyde Ward said the staff were “good people” and told us that they were “well looked after”. These comments were shared with the senior charge nurses and the service manager at the feedback session.

On the day of our visit, there was a sense of calm in both wards, and where we observed activity, nothing was overly intrusive or rushed. We witnessed several interactions between staff and patients which although directive, this was done with warmth and care. There were also supportive interactions between staff, and the team’s commitment to care delivery was evident, supported by effective leadership in both wards. We provided this feedback to the management team at the end of our visit.

Care plans and nursing notes

We reviewed the care plans and nursing notes for nine patients across both wards. We found detailed notes on the patients that were concise and provided up-to-date information. In Brandon Ward, the care notes were sub-headed to ensure consistency of information and were easy to read. The care plans reflected the multidisciplinary team discussions, and were reviewed on a regular basis. Care plans and nursing notes were recorded on the electronic system, MORSE, although there were the paper records that captured details about Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR), welfare guardianship orders and power of attorney information. Life storybooks were also kept with the paper notes for accessibility. Risk assessments were robust and detailed. The use of the traffic light system made it easy to see where the risks were identified, with subsequent further explanation later in the assessment.

Multi-disciplinary team (MDT)

The MDT meeting notes were concise, detailed and reflected the patient’s progress on a weekly basis. Previous decisions were noted, the current situation discussed, with outcomes and plans detailed at the end of the meeting minute for each patient. This highlighted the patient’s journey and supported ongoing decision making by the MDT.

All MDT notes were recorded on MORSE although we were pleased to find that one of the medical team printed out their notes and these were then stored in the patient’s paper folder. We felt this was positive and gave easy access to the most recent decisions at MDT.

In Brandon Ward, MDT staff contacted the family or carer prior to the meeting to ensure they were offered the opportunity to identify any issues or concerns; the consultant psychiatrist would then try to speak with the patient or observe the patient at a distance. Following the MDT staff would update the families or carers. Families and carers were also invited to attend the meeting and after the meeting, staff would check with them that they had fully understood any changes that had been discussed.

In Clyde Ward the patients could attend the MDT if they wished to, and this was also offered to carers and families. Similar to Brandon Ward, if families did not attend, the nursing staff contacted them after the MDT to provide an update.

Use of mental health and incapacity legislation

On the day of our visit, 12 of the patients in both wards were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). Where patients were subject to treatment under the Mental Health Act, all appropriate paperwork was in place.

Where patients are subject to power of attorney (PoA) or welfare guardianship orders under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), we saw that copies of the orders or PoAs on file and the proxy decision maker was noted on MORSE.

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 Act. On our previous visit we recommended that s47 certificates should be discussed with the proxy decision maker. We found evidence of this in the care notes. We did however note that although s47 certificates were in place for patients who met the criteria, the treatment plans for some lacked detail. We raised this at the feedback session and on our next visit we would like to see that treatment plans were reflective of the discussions in the MDT.

Rights and restrictions

Brandon and Clyde Wards have a locked door for access/egress to the wards, commensurate with the level of risk identified in the patient groups.

On the day of our visit there were no patients who were on enhanced observations and no specified persons on either ward during our visit. We did not see any advance statements on the files we reviewed. This was likely to be because of the cognitive impairment of the patient groups on the wards.

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

Those individuals that we spoke with talked of enjoying dominoes, gardening, quizzes, a newspaper group and walks with the occupational therapist. Therapet had recently been re-introduced to the wards and this was welcomed by patients who could enjoy interactions with the pets on their visits. There was a well maintained, well laid out garden that was shared by the two wards. There was protective fencing around the access to the garden from Brandon Ward that could be opened up for patients to enjoy the whole garden space and that allowed for patients from both wards to enjoy the fresh air and seating areas. We heard from one patient in Clyde Ward it was their responsibility to water the flowers and plants in the garden.

We were told that Clyde Ward has access to a minibus, and they were able to take the patients into the community. Their last outing was to a local museum, and they also go to garden centres, local events and cafes. The patients could choose the outings if there was something of interest.

We heard about the efforts of nursing staff to ensure there was always activity available for patients. There was an innovative games console, Tovertafel, available in Brandon Ward. Tovertafel provides interactive games that are projected onto a table; the console has been developed for people with cognitive challenges. We were told that this is well used by patients on the ward.

Both wards keep records of patients' activity in a separate folder. This provided ongoing information about each patient's activity undertaken that was then recorded on MORSE. We found that by recording activities in a separate paper-based folder, they were easily accessible to the wider care team.

Staff used Life Storybook information to offer targeted activities for individual patients. Recording was based in the Pool Activity Level (PAL) instrument, which is widely used as the framework for providing activity-based care for people with cognitive impairments, including dementia.

The physical environment

On our previous visit in November 2021, we made recommendations that neither Brandon nor Clyde Wards were fit for purpose. On this visit there was building work being undertaken in Brandon Ward to change one of the dormitories into a multi-function room and a family room. The ward was bright and airy, with dementia-friendly colours on the walls and clear signage on doors.

Clyde Ward was also bright and airy and has benefitted from new soft furnishings and fittings. The SCN told us that they would like to see the same building work that is taking place in Brandon Ward being undertaken for Clyde Ward so that patients and visitors would benefit from having areas for privacy, away from the main ward. We discussed this with the service manager during our visit and they advised us of their hope that there would be capital budget funding available to replicate the work being done in Brandon Ward in Clyde Ward. We look forward to seeing how this work has progressed when we next visit.

The single rooms in both Brandon and Clyde Wards do not have any showers, only toilet facilities. The construction of the building would not allow for shower facilities to be installed in each room as this would require major structural work to be undertaken.

Recommendation 1:
Managers should seek capital investment to make the changes required in Clyde Ward.

Summary of recommendations

Recommendation 1:
Managers should seek capital investment to make the changes required in Clyde Ward.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the 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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