Mental Welfare Commission for Scotland

Report on announced visit to:
Wards 19 and 20, Hairmyres Hospital, 218 Eaglesham Road, East Kilbride, Glasgow, G75 8RG

Date of visit: 10 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

Ward 19 is a 26-bedded unit that provides assessment and treatment for adults who have a mental illness from the South Lanarkshire area of Hamilton, Blantyre, Larkhall and Stonehouse. 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 care plan reviews and care plan audits and on ensuring that when people are subject to Adults with Incapacity legislation that a section 47 certificate is completed appropriately.

The response we received from the service was that nursing staff would be briefed on care plan reviews to ensure that individual's progress will be reflected in the care plans and that monthly audits would be undertaken by team leads. We were also advised that people who require section 47 certificates under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) would be discussed and reviewed at the weekly ward multidisciplinary meeting.

On the day of this visit, we wanted to follow up on the previous recommendations and actions reflecting progress on them.

Ward 20 is a 26-bedded unit that provides assessment and treatment for adults who have a mental illness from the East Kilbride and Clydesdale areas. On the day of our visit there were no vacant beds.

We last visited this service in April 2024 on an announced visit and made recommendations on care plan reviews and care plan audits and that appropriate consent to treatment forms are accurately completed and up to date. We also recommended that the managers consider progressing the post of an activity co-ordinator for the ward.

The response we received from the service was that monthly audits would continue to be completed and additional audits would be undertaken by the senior nurse. The outcome of audits would be discussed at clinical quality meetings. Consent to treatment forms would be reviewed at multidisciplinary meetings and a pharmacy technician would commence audits of the forms to ensure ongoing compliance. Progressing the post of an activity co-ordinator had been a previous recommendation and it was hoped that this would have taken place as part of the recruitment process.

Who we met with

We met with, and reviewed the care of 13 people, 10 who we met with in person and three who we reviewed the care notes of. The Commission's engagement and participation (E&P) officer met with five people. We did not meet with any relatives.

We spoke with the service manager, the senior charge nurses (SCNs), one charge nurse and a student nurse. We also met with the lead occupational therapist (OT), the occupational therapist, the peer support worker, ward pharmacist and the pharmacy technician

Previous staffing challenges have improved and Ward 19 is fully staffed and Ward 20 has three vacant RMN posts, although are in the process of recruitment.

Commission visitors

Anne Craig, social work officer

Mary Hattie, nursing officer

Susan Hynes, nursing officer

Sandra Rae, social work officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

Without exception, the people that we spoke to were complimentary about the care and treatment they received. Some comments were that the care was “exceptional”, “brilliant”, “amazing”, “good”, “fantastic”, “professional” and “great”. Other people told us that they “felt very safe”, “felt secure and felt safe”, “trust with staff”. Others told us that the staff “always make time to talk”, “explain what’s going to happen” and “include family in the MDT”. Another commented that staff were “spot on”. Throughout the visit, we observed positive, compassionate and beneficial interactions between staff and individuals, and staff we spoke with knew people well.

We were told by many individuals that the food was “terrific”, “good”, “fine” and “edible” with one person saying that the food was inedible and required food to be brought in to them from home.

A few people commented on the ward being closed down at 11pm and people requiring to be in their rooms by this time. One person said that this was not always conducive to supporting their sleep pattern as it sometimes meant that they were lying awake in their room for some considerable time without being able to move around the ward. We spoke to the nursing team and were advised that following medication being administered people are asked to retire to their bed areas, exceptions can be made for certain people who wish to finish watching a film on TV or similar but the purpose of this is to promote a good sleep pattern. Hourly checks are completed during the night and if anyone is noted to be awake staff will be aware of this and provide support.

Care, treatment, support, and participation

Care records

Electronic records are stored on MORSE and some information was held in paper files on the ward, such as detention paperwork and personal information. MORSE is an intuitive system to use and information is easily accessible. The most recent input to the system was immediately available. Continuation notes were well written and day staff used the SBAR format, although we did note that records completed by night staff were not in this format and were generic in language and contained less detail.

Recommendation 1

Managers should ensure that continuation notes are completed in a form that is consistent with both day and night staff.

The care plans were person-centred, detailed and reflected the goals and objectives for individuals. They linked well to the discussions and decisions at the weekly multidisciplinary team (MDT) meetings. There was evidence of individuals and

families having input to the care plans but we were concerned that there was a lack of comment and evidence of information as to how the MDT meeting incorporated the views of families and carers.

We noted that care plans were in place where there were concerns about physical health; these were detailed and included actions that were taken were a person to become physically unwell.

There was evidence of care plan reviews and monthly audit although these were less easy to find and identify. On previous visits to both wards we made recommendations about ensuring care plan reviews and audit were completed. We were pleased to see on this visit that these recommendations have been fully implemented.

Throughout the care records there is evidence of one-to-one meetings taking place and these were recorded and detailed.

Risk assessments were robust, detailed and up to date and used the traffic light system. A few people who had been recently admitted had an initial 72-hour care plan in place. There were timely MDT meetings that provided the forum for more person-centred and detailed care plans to be created to support the person's care during admission.

Multidisciplinary team (MDT)

The multidisciplinary teams consisted of psychiatry, nursing staff, occupational therapy staff, psychology and pharmacy. The wards do not currently have a dedicated psychologist but cover was provided by one of the clinical psychology team, who was able to see people on the wards, and a new member of the team will fill the role shortly. Referrals could be made to all other services as required.

The multidisciplinary team in Ward 19 consisted of five consultant psychiatrists, two of whom were specifically for people who suffered from addiction issues and were shared with Ward 20. In Ward 20, there are seven consultant psychiatrists, including the two whose input was specifically for people with addictions.

The MDTs meet with individuals on a regular basis. Individuals commented that they met regularly with their consultant and comments were mostly positive about their interactions. Regular access to medical staff was helpful and comments from individuals highlighted the positive relationships they had with the whole multidisciplinary team.

MDT notes had relevant content and set out the discussions that had taken place with attendees. There was a lack of information on each individual's views, and we were also told by one person that her relative, who knew her best, was not invited to the multidisciplinary meeting. We saw that for some, there was involvement of family

members. We were told that if family members chose not to attend then the consultant would try to contact them after the meeting (with the person's permission) or if unsuccessful, then a member of the nursing team would contact the family member to provide update.

Recommendation 2
Managers should ensure that individuals, families and carers are invited to attend the multidisciplinary meetings, and their views recorded.

We were also told that as the person progresses towards discharge, community support services will also attend the multidisciplinary meeting; this may include social work, community psychiatry and community support services. We were told that in Ward 19 there were four people and in Ward 20 there were two people whose discharge from hospital had been delayed. We were assured that anyone whose discharge was delayed was discussed regularly with the discharge co-ordinator and the service manager.

As a result of our previous recommendations made about ensuring appropriately completed consent to treat forms, pharmacy support had been introduced to ensure compliance with T2 and T3 certificate (MHA). We found that this was working well and we were pleased to hear that pharmacy was not only available to the clinicians, but that they attended MDT meetings and would speak to individuals and relatives about their medications.

Use of mental health and incapacity legislation

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

We found all documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment were reviewed. In one case, we noted an IM 'as required' medication was on a T2. The Commission has concerns about IM 'as required' medication being included on a T2 certificates, as any advance consent the individual has given would be invalid if they have withdrawn their consent at a later time when the medication is given or if restraint is involved. It is our view that where IM medication has been prescribed 'as required' in hospital, it should be authorised on a T3 certificate. We discussed this with one of the nursing team who advised that this person does request any as required medication to be given IM, rather than oral medication on the occasions that this is given and confirmed this is not given without their consent.

On the day of the visit, in Ward 19 there were eight people and in Ward 20, nine people were detained under the Mental Health Act

People we spoke with who were detained under the Mental Health Act mostly had a good understanding of their rights, any restrictions that were in place and how to appeal against their detention. One person was in the process of making an appeal and was supported by advocacy services.

We heard from several people who spoke positively about advocacy services and we noted that advocacy was active in the wards. We saw that staff had received training on rights and a person's rights were discussed at the MDT meetings, during one-to-ones and in advocacy sessions. Staff had a direct email link to access the Commission's *Rights in Mind* guidance which could be given to people to further increase their knowledge of their rights.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests, they are called a named person. We did not see any named person paperwork on file.

Where an individual lacks capacity in relation to decisions about physical health treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 Act (the AWI Act) must be completed by a doctor. There were several individuals subject to the AWI Act and who had section 47 certificates in place, which were in order. 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.

One person had a welfare guardianship in place and this was noted in the paperwork but there was no copy of the document on file. This was brought to the attention of the SCN who intended to seek a copy from the guardians as soon as possible.

Recommendation 3
Managers should ensure that copies of relevant documents, e.g. Power of Attorney and Welfare Guardianship Orders, are provided to the ward at the earliest opportunity following admission.

Rights and restrictions

Ward 19 and ward 20 have an open access policy and during our visit we noted doors at the entrance/exit were open and people were moving around freely. However, we also noted that these exits were monitored by staff who rotated hourly to ensure that there was detailed information about who was in/out of the wards. These observations were unobtrusive and did not detract from the ambience of the wards.

There were a number of informal individuals across both wards. We were concerned to hear that all people new to the wards were not allowed outdoor access, even if they were informal, for the first 72 hours of their admission and if they insisted then their admission would be reviewed and they may be either detained or discharged. We asked about this practice and were told that each person is viewed individually and their risk assessed as each new admission brings new challenges.

Across both wards, there were six people being nursed under Clinical Observation and Engagement Policy. For some people, they were being cared for in their rooms but others were able to walk about the ward with a member of staff. These observation levels were provided in response to the needs of the individual rather than the needs of the ward. One person spoken to who was on increased clinical observation advised that his nurse for the day was "solid".

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied.

There were three people where specified person restrictions were in place under the Mental Health Act. We saw that one person had their specified person status revoked on the morning of the visit and two others remained in place, with one individual having restrictions on telephones and correspondence. All paperwork was on file and reasoned opinions had been completed. One person who was specified confirmed they had received the information in writing but advised they were not concerned about the restrictions.

When we are reviewing individual's care records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and are written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any statements on file but we note that staff were familiar with the Commission's materials on advance statements and the requirement to action what has been stated in the care plans, if possible. We are also told that advance statements are discussed with people as they approach discharge.

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.

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

Activity and occupation

A previous recommendation was for the service to consider progressing the provision of an activity co-ordinator. We were disappointed to note that to date, this has not been approved.

There were mixed comments about the activity on offer. One person told us that "there's not much to do" and it was "boring", but another told us that "there was a good variety of activities". We were told that there were plenty of DVDs but we found no DVD player on the ward and that there was a selection of Nintendo games but no console. There was a pool table and a new dart board. There was also gardening and this is facilitated by occupational therapy staff.

We acknowledge that the peer support worker is a valuable asset to the wards. Feedback from individuals has been extremely positive, one person told us that the peer support worker was "wonderful".

We still consider that this is a gap in the service and provision of an activity co-ordinator could enhance the experience of an admission to an acute ward.

Recommendation 4

Managers should continue to progress the provision of an activity co-ordinator to the wards.

The physical environment

Both wards consisted of single rooms and shared dormitories. There are lounge areas and separate dining areas for people, as well as quiet areas. The main corridors are bright and airy with a good standard of décor.

We noted individual rooms looked tired and were in need of refreshing. We saw patched areas of paint applied and some rooms were a mixture of different colours of off white/cream. Staff had made efforts to soften some of the communal areas although we do feel that there is a need for a whole refresh of the ward. We were told that particularly in Ward 20, the furniture in the day room is stained, damaged and uninviting. Requests for replacements are being considered but has not yet progressed due to availability of funding.

New windows had been installed since our last visit and this enhanced the privacy and ventilation in all the rooms, as well as minimising disruption as people were trying to rest in their rooms.

The wards benefit from good outside space for people to use. These areas were adequately maintained and on the day of our visit we saw people use this as a pleasing space to enjoy. The Commission considers that it is important for individuals to have access to outdoor safe space and we heard how access to the garden from Ward 19 really helped people where fresh air was important for their

wellbeing. Accessing this outdoor space was more challenging for people in Ward 20.

We were told by staff that at times, particularly in Ward 19, the temperature fluctuates as it is centrally controlled; at times the ward environment can be cold as air vents blow out cold air regardless of the room temperature.

Recommendation 5
Managers should ensure that temperature in the is kept at an optimum level for the comfort of staff and individuals.

Several people commented on those who smoked or vaped in the immediate area outside the wards; we witnessed people smoking/vaping at the entrance area. We were also told that on occasions, people were vaping in their bed area in the ward. We discussed this with the SCNs and their manager. We were advised that while staff were aware of the legislation that no smoking or vaping is allowed in hospital grounds, it is hard to ensure that this does not happen. Staff feedback advised of offers of smoking cessation options such as nicotine replacement patches, inhalers and sprays but these could not be forced on an individual. We are advised that this is regularly discussed at management meetings and remains on the agenda for discussion. We are particularly concerned at the comment that people vape while on their beds and we are assured that this does not happen.

Recommendation 6
Managers should continue to ensure that smoking/vaping is not allowed on the hospital grounds and regularly discuss factors to mitigate occurrences in the ward areas and beyond.

We were told that the visiting time had suddenly changed which prevented family visiting at a time that would suit them. We were told that visiting times are from 2pm till 4pm and 6pm till 8pm. These times are in place to ensure protected mealtimes for the people on the ward but if visitors and relatives are unable to attend during these times it is not uncommon for visits to be agreed out with these times.

We were pleased to note that on the day of our visit, at the entrance to both wards, information about Mental Welfare Commission visit and how to speak to one of the Commission staff was prominently displayed.

Summary of recommendations

Recommendation 1
Managers should ensure that continuation notes are completed in a form that is consistent to both day and night staff.

Recommendation 2
Managers should ensure that individuals, families and carers are invited to attend the multidisciplinary meetings, and their views recorded.

Recommendation 3
Managers should ensure that copies of relevant documents, e.g. Power of Attorney and Welfare Guardianship Orders, are provided to the ward at the earliest opportunity following admission.

Recommendation 4
Managers should continue to progress the provision of an activity co-ordinator to the wards.

Recommendation 5
Managers should ensure that temperature in the is kept at an optimum level for the comfort of staff and individuals.

Recommendation 6
Managers should continue to ensure that smoking/vaping is not allowed on the hospital grounds and regularly discuss factors to mitigate occurrences in the ward areas and beyond.

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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