

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Brandon Ward, Udston Hospital, Farm Road, Burnbank,
Hamilton ML3 9LA.

Date of visit: 6 July 2026

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

Brandon ward is a 20-bedded, mixed-sex admission and assessment unit for people over 65 years old, with a diagnosis of dementia.

On the day of our visit, there were 19 people on the ward, with one individual being cared for in a general hospital for their physical care needs; there were no vacant beds.

We last visited Brandon and Clyde wards in May 2023 on an announced visit and made no recommendations for Brandon ward. At the time of the last visit, building work was being undertaken to change a dormitory into a multifunction room and family space.

On the day of this visit, we wanted to hear about how the new space was being used. We were aware that the Hospital-Based Continuing Complex care (HBCCC) beds which were previously available in Hatton-Lea Nursing home were closed in 2025 as the provider considered the environment was no longer suitable. We wanted to find out how the closure of the HBCCC specialist dementia beds had impacted the ward flow.

Who we met with

We met with, and reviewed the care of 12 people, five who we met with in person and seven who we reviewed the care notes of. We also spoke with six relatives.

We spoke with the service manager, the charge nurse, the lead nurse, one of the consultant psychiatrists.

In addition, we met with student nurses and staff nurses.

Commission visitors

Alison Thomson, nursing officer

Tracey Ferguson, social work officer

Laura Young, nursing officer

What people told us and what we found

We spoke to and observed individuals in Brandon Ward. Most of the individuals were unable to engage in lengthy discussion about their care, but it was evident from observation that staff had a good knowledge of individuals' needs and were responsive. Individuals sought out staff members and appeared happy to see familiar faces. We noted that individuals appeared settled and content in the environment.

We spoke to six relatives who all praised the ward and staff. We were told that the staff care about the family as well as the individual. We heard a range of positive comments including 'I don't feel a bother', 'the staff love her', 'they meet mum's needs', 'the care he gets is the best', 'they keep you up to date', 'I can visit any time and I'm always welcomed', 'staff come up with out-of-the-box ideas that really help'. The relatives all gave information about how small changes in care had made a big impact on the life of their loved one, including doll therapy, specialist seating and small changes in visiting times. Families felt these individualised suggestions demonstrated staff had a good knowledge of their loved ones needs.

Relatives and carers also told us they got support from the staff team and valued this. They liked being able to see other visitors while they were in and felt this gave them additional support.

On the day of the visit the ward was short staffed. We were told that a staff member was allocated to activities for an hour in the morning, afternoon, and evening. We saw positive interactions between staff and individuals, which demonstrated staff had a good knowledge of individual's preferences. We saw some activities taking place on a one-to-one basis with individuals. The ward had a calm, relaxed feel and staff were visible in communal areas.

Care, treatment, support, and participation

The care records were mainly held on the electronic system, MORSE, but some paper records were stored separately, including do not attempt cardiopulmonary resuscitation forms (DNACPR), national early warning system records (NEWS), life story work, ICP, post falls paperwork, guardianship and power of attorney paperwork. There were additional paper notes for staff, including agency workers, to complete where they had no access to the system.

We reviewed the care plans and notes of seven individuals. The daily notes were structured to include details about presentation, activities of daily living (ADLs), physical health, communication and legal status. This added detail to the progress notes and covered all aspects of physical and mental health presentation each day.

Between MORSE and the paper system, this led to a slightly disjointed record. We were advised that NHS Lanarkshire were looking at ways to allow regular agency staff to have access to the electronic system. In spite of seeing evidence of activities on the ward, we found little mention of this in the progress notes and thought this could be improved.

NHS Lanarkshire is developing a new risk assessment tool in line with current best practice guidance. This is in the piloting stage and has not been introduced to Brandon Ward. We found the current risk assessments were completed well, regularly updated, and detailed. We felt some of the risk management plans could be enhanced with more detail around strategies, to be more in line with the level of knowledge staff have of the individuals.

The care plans covered a range of needs and were detailed; there was evidence of regular reviews. We felt that the stress and distress care plans could be more personalised with details about triggers and how to manage these. We saw evidence of personalised stress and distress management on the ward but felt this could be reflected in greater detail in the care plans. We found some similarities in the care plans and wondered if a template had been used as a base, which led to them not being personalised enough. This was fed back at the end of the day and we were told this would be addressed.

We heard ward staff can easily refer to psychology, who will then attend the ward; most staff had undertaken stress and distress training. NHS Lanarkshire has developed a new modular training in collaboration with North and South Lanarkshire HSCP called 'FOCUS' (facilitating outstanding care and understanding strategies) which all staff are being supported in working through. This will allow staff to practice at the skilled level of the promoting excellence framework. FOCUS replaces the Dementia Champion course that had previously run for many years. We look forward to hearing how this improves the care and documentation on the ward.

We heard from relatives about how involved they felt in the care planning process and in all aspects of their loved one's care, but this was not reflected in the care plans. We fed this back at the end of the day.

Recommendation 1:

Managers should ensure that care plans are personalised and reflect the needs and preferences of individuals and that the participation of individuals' families/carers is evidenced in the care plan or individual's file.

The Commission has published a good practice guide on care plans¹. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

Multidisciplinary team (MDT)

Brandon Ward has four MDT meetings a week, one for each geographical area that is covered. There are three consultant psychiatrists covering the ward and they all work in a similar way. Two of the consultants cover their geographical area for inpatient and outpatient, and the other covers two geographical areas for inpatient.

The MDT notes were clear and concise. Each individual's journey was easy to follow and detailed this on a week-to-week basis. There were clear goals and outcomes for each individual. Relatives and carers were invited into the MDT meetings and outcomes were fed back to those who were unable to attend. We noticed that most MDTs were attended by nursing staff and medical staff, with fewer examples of other members of the MDT in attendance.

We heard that psychology is not based on the ward, but a referral can be made and is picked up quickly. We did not find evidence of formulations in the notes we accessed, and some of the stress and distress care plans required more detail. We saw evidence of skilled stress and distress interventions taking place in the ward and it was evident both from our observation and relative and carer feedback that nursing staff work in a positive person-centred way to reduce stress and distress.

Due to the clinical acuity of the ward, there may not be sufficient time for nursing staff to develop the care plans that reflect the work they are doing. It may be beneficial for increased dedicated psychology input in the ward to enhance the current work and contribute to the risk management plans.

We saw evidence of OT, physiotherapy, and pharmacy input. Pharmacy have created detailed covert pathway care plans and guidance which was available in the dispensing room. There is a clinical fellow who provides physical healthcare on weekdays and we could see physical health conditions were well supported and escalated where appropriate.

Delayed discharges were highlighted at MDT in response to escalating delays. The ward has introduced a delayed discharge co-ordinator who liaises with potential new placements, social work, and health. This is helping identify issues earlier and prevent longer delays. The ward has recently introduced a dedicated social worker and it is hoped this will help facilitate discharges in a timely manner and allow relationships to be built with families throughout the assessment process. There were eight delayed discharges on the day of our visit, with various reasons causing

¹ *Person-centred care plans good practice guide*: <https://www.mwcscot.org.uk/node/1203>

the delay, including finding placements, guardianship issues, and packages of care. We look forward to seeing how these new ways of working improve the process.

Following the closure of the HBCCC specialist dementia service in Lanarkshire some of the beds in Brandon were being used to support individuals who require this level of care. This has had an impact on the number of beds available and affects the overall function of the ward and the potential to move other people who may be identified as suitable for HBCCC. The individuals who require HBCCC care are reviewed quarterly, in line with guidance. The ward has managed this well but it has had an impact, not only on the running of the ward as an assessment ward, but also with future placements for people requiring specialised dementia care who cannot be accommodated in other areas.

Recommendation 2:

Managers should consider the future of specialist dementia care for those who cannot be managed out with a hospital setting.

Use of mental health and incapacity legislation

On the day of the visit, 12 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

The relatives and carers we spoke to had an understanding of the legal status of their loved ones and told us they were kept informed about potential changes. On the day of the visit, we were unable to engage meaningfully about the legal status with any of the individuals who were subject to the Mental Health Act.

Part 16 of 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 that for all people who required a T2 or T3, these were in place, uploaded to MORSE and the date of upload and information from the form was available in the notes section of HEPMA, the electronic prescribing system. This allowed nurses to check the uploaded form at the point where they were dispensing medication and this was reviewed at the MDT meetings, to ensure that the information remained up to date.

We found two issues with T3s - a delay with a DMP visit and a change in medication which had not been reflected in the T3. These were in the process of being addressed at the time of our visit. We found the information available in the notes section of HEPMA to be useful, as it noted dates of changes, the rationale for changes, and indicated if the person had a covert medication pathway in place.

For individuals who had covert medication in place, all appropriate documentation was in order, including recording of the reviews and the pathway where covert medication was considered appropriate. The Commission has produced [good practice guidance on the use of covert medication](#).²

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We did not find any individuals who had nominated a named person, which is not uncommon in this type of setting.

For the most part where individuals were subject to power of attorney (PoA) or welfare guardianship orders under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), we saw copies of the orders or PoAs on file; this was noted on the electronic records, or where they were not available it was noted that copies had been requested. The 'patient status at a glance' board had information about the status and noted the proxy decision maker's name, but this did not match with the electronic files. We were told that it could be difficult to get copies of the legal paperwork from relatives.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that the treatment complies with the principles of the Act. The doctor must also consult any appointed legal proxy decision makers and record this on the form. In the previous visit, it was found that some of the treatment plans lacked detail. On the day of our visit, 14 individuals required section 47 certificates under the AWI Act. We found the completion of treatment plans and discussions with proxy decision makers inconsistent on our visit. Some had been completed to a very high standard and others were missing care plans or discussions with proxy decision makers. We fed this back at the end of the day and were assured this would be addressed.

Recommendation 3:

Managers should ensure that section 47 certificates are completed consistently in line with the code of practice; including a care plan and records of any discussion with proxy decision makers.

Recommendation 4:

Managers should ensure there is clear recording and auditing of welfare guardianship and power of attorney documents.

² Covert medication good practice guide: <https://www.mwcscot.org.uk/node/492>

Rights and restrictions

Brandon Ward has a locked door for access/egress to the ward, commensurate with the level of risk identified in environment. There was no sign on the ward door due to it having been ripped off the wall by an individual, however before we left a new sign had been put up to make people aware of the locked door policy and their rights in relation to this.

We noted there was regular advocacy group meetings in Brandon Ward and access to advocacy was recorded in the electronic records. The ward had a leaflet they gave to individuals and relatives which signposted families and carers to where they could get more information in relation to rights and advocacy.

On the day of our visit there were no individuals being supported with enhanced observation, and no individuals who were restricted as a specified person. We did not see any advance statements, but we did see evidence of 'Getting to know me' paperwork.

There was one person who required mechanical restraints in the form of a groin strap in a specialist chair. We saw evidence of this being discussed with the proxy decision makers, and the use of this was reviewed regularly in a specialist care plan.

There were room and bed sensors in place for individuals who were at risk of seizure activity/ falls. These were care planned for, discussed with relatives and professionals and regularly reviewed.

The Commission has developed [*Rights in Mind*](#).³ 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

We saw evidence of activities with individual taking place on the ward. Some staff are able to drive the minibus and can facilitate outings, which we heard individuals enjoy.

We heard about trips to the seaside and local cafes. On the day of the visit, we saw staff reading the paper to individuals, playing dominoes, and chatting with people. We did not see any organised activities, which may be due to the stage and impact of people's illness.

We saw photos of activities that took place in the ward garden. There is a Tovertafel interactive system available in Brandon Ward, which is an innovative games console that projects games onto a table. At the time of our visit, it was not being used, as

³ *Rights in Mind*: <https://www.mwcscot.org.uk/law-and-rights/rights-mind>

the area it is was normally kept in was being used as a low stimulus environment to support someone who was benefitting from that.

Families told us about activities that their loved ones had participated in while in Brandon Ward and how these are personalised in line with preferences and needs. We heard how staff were managing to facilitate activities with their established numbers. Although there were times that there has been a shortage of staff, we were told that activities were prioritised.

We are aware that NHS Lanarkshire is in the process of approving posts for activities co-ordinators, and we feel this would be of great benefit in Brandon Ward as it would enhance the existing activities.

The physical environment

Brandon Ward is a large unit; it is bright and airy with multiple areas for people to sit. There is a large conservatory, a day room and a quiet room, which was being used as a low stimulus room at the time of our visit. There is a multi-function family room and big, bright corridors where we saw individuals resting in the various seating areas with access to a secure garden.

The multipurpose/ family room is used to support relatives to be with their loved one at the end-of-life stage and is a positive resource allowing a more personalised approach. When it is not needed for this purpose, it is also used for visits and meetings with families. It has comfortable furnishings and resources for families to store items in a fridge and make hot drinks and snacks.

On the day of our visit, we found the conservatory was being used to store the furniture that would normally be in the quiet room, in order to facilitate the use of the low stimulus room. It meant the conservatory was less accessible to individuals.

There are dormitory bedrooms which hold up to six beds, with each dormitories having access to a toilet and shower room. There are five single rooms which have an ensuite with a toilet and sink but share a communal shower room off the main corridor.

We were told that the building was not suitable for ensuite shower rooms. We found that some of the single rooms had unobstructed views from the corridor into the bed area posing some concerns regarding privacy. We heard there had been privacy screen on the glass from the corridor, but this had been removed by an individual. Some rooms had curtains in line with the individual's assessed risk, but others had privacy glass, which we thought this might affect the quality of sleep during the summer months. We were told this was considered on a case-by-case basis and where possible, curtains would be put up to make the room more homely.

There were some concerns about the single rooms either being too open to the corridor or having no observation from the corridor. We were told this was being looked at in the coming weeks and we look forward to seeing how this has been addressed.

On the previous visit there had been a large communal bathroom, but the bath had been removed and not replaced. This room is now used as a toilet. The communal shower room had a strong smell from the drains; we were told that this is regularly reported to maintenance, and addressed, but this quickly becomes an issue again. We felt this might affect individual's motivation to shower and their enjoyment of the experience. The loss of the only bath in the ward removes the opportunity for individuals who prefer a bath to a shower to have this accommodated.

Recommendation 5:

Managers should consider seeking capital investment to improve access to shower/bathing facilities that are modern and able to cope with the volume of use.

Any other comments

We heard about a staff member who had taken on the role of carer's champion for the ward and how this is improving the links between staff and relatives/carers.

We also heard about the quality improvement group which has been running for approximately eight years; it is multi professional in nature and has resulted in many benefits for the ward including the upgrading of the garden and the introduction of a visitor space which is situated outside the ward.

We observed that the staff in the ward are working well with individuals and their families and we saw genuine care in their actions; we considered that with additional staffing, this could be enhanced and reflected in the care records.

Summary of recommendations

Recommendation 1:

Managers should ensure that care plans are personalised and reflect the needs and preferences of individuals and that the participation of individuals' families/carers is evidenced in the care plan or individual's file.

Recommendation 2:

Managers should consider the future of specialist dementia care for those who cannot be managed out with a hospital setting.

Recommendation 3:

Managers should ensure that section 47 certificates are completed consistently including a care plan and records of any discussion with proxy decision makers.

Recommendation 4:

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Recommendation 5:

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Good practice

We felt the quality improvement group is an example of good practice and demonstrates how staff can influence changes to the environment of their ward to benefit the individuals they care for.

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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