Mental Welfare Commission for Scotland

Report on announced visit to: Huntlyburn House, Borders General Hospital, Melrose TD6 9BP

Date of visit: 23 February 2022

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 local visit was carried out face-to-face.

Huntlyburn House is a mixed-gender adult acute inpatient unit with 19 beds for patients aged 18-69 years with mental ill health diagnoses. The unit is based in the grounds of the Borders General Hospital. The ward is staffed by a senior charge nurse, charge nurse, registered nurses and support workers. The consultant psychiatrists from all areas in the Borders retain responsibility for patients when they are admitted to the ward. There is also significant input from occupational therapy, physiotherapy, a clinical aromatherapist and junior doctors.

On the day of the visit there were 11 patients of which three were outwith the admission criteria for the ward as there were no appropriate beds available in other areas. We last visited the ward on 2 October 2019 and made recommendations in relation to care planning and the use of restrictive practices.

On the day of this visit we wanted to meet with patients and relatives and follow up on the previous recommendations. We were aware that priorities had to be identified during the pandemic.

Who we met with

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

We spoke with senior charge nurse (SCN), deputy charge nurse (DCN), clinical nurse manager (CNM) and the service manager.

Commission visitors

Susan Tait, Nursing Officer

Alyson Patterson, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

From the relatives that we spoke with, they had differing views; one was extremely happy with the care and communication and commented particularly on the holistic approach by the physiotherapist. The other relative reported that the treatment was "ok" but commented that communication about their relative's care was forthcoming only if they approached staff. We discussed this on the day of the visit with the staff team.

NHS Borders uses the electronic system EMIS for all patient records. The ward staff have decided that due to difficulty in accessing care plans and involving patients in their own care, that they now print out the plans and keep them in a folder. At the end of the episode of care they are uploaded to EMIS.

The care plans we reviewed varied from detailed and person-centred to others which lacked detail and in one case there were three unrelated issues incorporated into a single care plan. We observed for most of plans that there were thoughtful reviews. From our last visit there was a recommendation in relation to care plans, however we observed during this visit that care plan quality continues to be of variable quality.

Recommendation 1:

Managers should ensure that care plans are regularly audited to help ensure a consistent approach to care planning.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Multidisciplinary Meetings

We noted that multidisciplinary meetings (MDT) are held weekly with the range of professionals involved in the patients care and where patients wish to attend.

On the day of our visit Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') paperwork in the record was easy to access.

Part 16 (ss235-248) 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. The authorising treatment forms (T3) were in order. A (T2) is completed where a patient is capable of consenting to their treatment. There were no patients at this time who required a T2.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act '(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 AWI Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. The AWI Act section 47 consent to treatment certificates were in order along with accompanying care plans.

Where a patient had an appointed proxy decision maker in place, we were unable to find power of attorney (POA) documents in the file. It was unclear if there was a person appointed with the appropriate legal authority; we brought this to the ward manager's attention on the day of our visit.

Rights and restrictions

We reviewed the care in relation to enhanced observations for one patient. On discussion with nursing staff, it was considered that there were higher levels of restrictions in place than were necessary, taking into account the reason and risks associated with the restriction. We were unable to identify a care plan to support the application of the restrictions. Any level of enhanced observation placed on patients must reflect the risk and take into account the principle of 'least restrictive alternative'. We asked ward staff for this to be reviewed.

During our previous visit we discussed that restrictive practices, in particular the use of seclusion, should be carefully monitored and underpinned. We were told that there is now a draft policy awaiting final ratification. We look forward to seeing this in operation at our next visit.

Recommendation 2:

Managers and medical staff should ensure that the reason for restrictive practices are evidenced and are the least restrictive alternative.

Activity and occupation

There is a morning meeting each day called 'positive steps' which patients are encouraged to attend. There is a plan made each day for activities, and patients have access to an extensive garden area with greenhouse and raised beds where vegetables and flowers are grown. Currently, there is a nurse seconded to develop the 'space to grow' therapeutic input. The plan varies from day to day depending on what patients want and what is available. Patients are usually offered craft activities, a walking group, cycling and tai chi. A clinical aromatherapist is available once a week. The groups are led three times a week by an occupational therapist (OT) and by nurses at other times.

The physical environment

In the report from our previous visit, we noted that the public areas of the ward were somewhat clinical in appearance and would benefit from having a more welcoming feel. We noted little change during this visit, however we appreciate that Covid-19 has had a significant impact on ensuring environments meet the necessary standards of infection control. We were told that

the ward had been gifted a large amount of art work and ward staff were in the process of having these made ready for hanging on the ward.

There was a notice in the ward to remind patients not to enter others bedrooms, however there was nothing to identify rooms, apart from room numbers. We would suggest that some way is found to help patients personalise and identify their own bedroom area, without comprising privacy and confidentiality.

Summary of recommendations

1. Managers should ensure that care plans are regularly audited to help ensure a consistent approach to care planning.

2. Managers and Medical staff ensure that the reason for restrictive practices are evidenced and are the least restrictive alternatives.

Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving 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 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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