Mental Welfare Commission for Scotland

Report on announced visit to:

Borders General Hospital, Borders Specialist Dementia Unit (BSDU), Melrose, TD6 9BS

Date of visit: 13 May 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

Borders Specialist Dementia Unit (BSDU) is a 12-bedded unit that provides assessment and treatment for individuals over the age of 69 with a diagnosis of dementia in the Scottish Borders.

On the day of our visit, there were 12 people on the ward.

We last visited this service in April 2024 on an announced visit and made recommendations related to care planning, psychology input and environmental issues with regard to individual bathrooms.

The response we received from the service was that two of the recommendations had been met, but due to budget constraints there was no finance available to change the environment to provide individual bathrooms.

On the day of this visit, we wanted to meet with people receiving care and treatment, review their care and treatment and follow up on the previous recommendations.

Who we met with

We met with six people and reviewed their care records. Although we were unable to have specific conversations about their views due to the progression of their illness, we were able to see that they seemed comfortable and at ease with the staff. We met with three relatives.

Prior to the visit, we had a virtual meeting with the senior charge nurse (SCN). On the day of the visit, we spoke with the SCN, other nursing staff, the consultant psychiatrist, the clinical psychologist and the art therapist.

Commission visitors

Susan Tait, nursing officer

Justin McNicholl, social work officer

Kirsty MacLeod, engagement and participation officer (carers)

What people told us and what we found

Throughout our visit we saw interactions between staff and individuals which were warm, good-natured and relaxed. We saw staff taking their time in their communication with individuals. There was a sense of calmness; staff we spoke to felt it was important that the people in their care felt safe and secure considering that the symptoms of dementia can, at times, cause individuals to feel disoriented and distressed.

Relatives we spoke with said that they were very happy with the care provided and were kept up to date with any changes. Views varied on involvement and although relatives said they were given information, they felt they did not always have an opportunity to have their views, and any concerns, raised at the weekly multidisciplinary team (MDT) meeting. We were aware that the team use an ‘open dialogue’ approach with communication but having the opportunity for relatives to engage in care planning and have any concerns or questions raised at the MDT would be invaluable. In addition, if relatives/carers hold power of attorney or guardianship, there is a legal obligation for them to be consulted.

Recommendation 1:
Managers should ensure that relatives/carers are routinely consulted prior to the MDT meeting and their views are recorded on the MDT meeting proforma.

Relatives commented that they would find it helpful to have an information pack on admission. This would help them read through information at their own pace and it would be helpful if it includes details such as what a key worker was, who the key professionals were, what to expect from the ward, and contact details for organisations such as carer advocacy. We discussed this at the end of day meeting, and it was agreed that this would be progressed. We will look forward to reviewing it at the next visit.

We chatted informally to individuals in the BDSU and those that we spoke with said “the nurses are lovely” and “the food here is good”.

During discussion with the consultant psychiatrist, we heard how much pressure the team were under and how ‘stretched’ they were to provide the input to the ward.

We spoke with the clinical psychologist who had recently joined the MDT. They spoke about supporting staff to use specific approaches for stressed and distressed behaviours and having a psychological formulation that aimed to create a shared understanding of individuals’ past experiences, which could guide the development of person-centred care planning.

The nursing staff team was almost at full establishment but we were told there was quite a high sickness rate.

We reviewed six sets of care plans and noted that the quality of these varied. Some described the interventions that were required and were very person-centred; others were more generic and lacked detail. This was disappointing to see as we had been advised that the audit process had been fully implemented and we have previously raised this with the associate nurse director (AND).

Recommendation 2:
Managers must review the care plan audit process to ensure that the qualitative information contained in the care plans accurately reflects the nursing interventions required to meet the identified care need.

It was positive to see that in all of the care plans we looked at there were thorough and detailed reviews, indicating if change was required to progress.

The Commission has published a good practice guide on care plans[1]. 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.

Each person had a 'what matters to me' board in their bedroom. This gave 'at a glance' information on the individual, their preferences for personal care, family contacts and anything else that was important to them. Relatives and carers could also add any information. We considered this would ensure consistency of care and assisted in providing the most person-centred approach.

At the time of our visit, there were two people who had been assessed as no longer requiring further NHS treatment and were awaiting care home placements. They were described as having their discharge from hospital delayed. One individual had been in hospital for a year and there were specific challenges in finding them appropriate support and accommodation. The discharge liaison manager who assisted with discharge planning was seeking out appropriate services to support a successful discharge from the ward.

Care records
NHS Borders uses the electronic recording system 'EMIS', which was not specifically designed with mental health care needs in mind. However, we were able to navigate the system reasonably easily.

When initially logging on to an individual's file there was an alert 'pop up 'which identified if the person had a power of attorney or welfare guardian in place, or if they were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). A nursing view on the individual's presentation over the

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

previous week was also used to provide an update of the care that was being delivered.

We were able to see when discharge planning was being considered at an early stage following admission and found these plans to be comprehensive.

All the files we reviewed had an up to date risk assessment in place, along with risk management plans. The 'Ayrshire Risk Assessment Framework' (ARAF) was used in the BSDU, which had superseded the Borders risk assessment. We noted that the paper copies of the risk assessment had not been updated with appropriate naming which could lead to confusion. We suggest that this information is updated and it was agreed at the end of day meeting with the service that this would be done.

In the continuation notes we reviewed, the quality of information varied about the person's presentation during the day, with some using non-descript phrases such as "low profile" and "evident around the ward", while others provided comprehensive detail of the individual's mood, or how interactions had been carried out. To remedy this, we suggested that some training may be required, and we signposted the service to the use of 'canned text' guidance that would support this.

Multidisciplinary team (MDT)

The MDT met weekly to discuss individuals' presentation, progress and any interventions required to ensure care and treatment met the needs of individuals admitted to BSDU.

We reviewed several of the notes for the MDT meeting and were pleased to find a consistent approach in recording details from these meetings. The MDT meeting comprised of nursing staff, consultant psychiatrist, the clinical psychologist, the associate physician, a discharge liaison care manager, mental health officers (when individuals were detained under Mental Health Act) and other disciplines, such as occupational therapy (OT) and pharmacy who attended where indicated.

We were advised that relatives were not routinely invited to the MDT meeting, but were invited to a separate family meeting, usually on admission or at the time of discharge; these could be arranged out with these times if required. We were told that nursing staff routinely contacted relatives after the MDT meeting to give any updates.

We were very pleased to see the addition of psychology to the team, which met one of the previous recommendations which had been repeated in several reports.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health Act. All 12 people were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

All legal documentation relating to the Mental Health Act and the AWI Act was in order and easily accessible.

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, with treatment being authorised by either a T2 or T3 certificate. Only one of the individuals detained met the timeframe threshold for the required T2/T3 certificates and all medications were authorised.

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 the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

For those people that were subject to the AWI Act, we found that everyone who had been assessed as lacking capacity to consent to their medical treatment had a section 47 in place, which was kept with their medication administration record. These detailed the treatment prescribed and consultation with the proxy, if there was one. We found that some of the certificates lacked detail about the treatment being authorised. It was noted that these ones had usually been completed in the general hospital. The section 47 certificates that had been completed on direct admission from the community all identified the treatment being authorised. We suggested that if people were being transferred from the general hospital with a section 47 in place, these should be reviewed to ensure they are appropriate.

For individuals who had covert medication in place, all appropriate documentation was in order.

The Commission has produced good practice guidance on the use of covert medication.[2]

We also reviewed the 'do not attempt cardiopulmonary resuscitation' (DNACPR) certificates and again the ones which had been completed in the general hospital lacked detail and did not indicate whether review was appropriate or note; we could see where welfare proxies had been consulted. We suggested that these also should be reviewed on admission and at the MDT meeting.

Rights and restrictions

The ward operated a locked door policy that was commensurate with the risks associated with the individuals in the ward. On the last visit there was clear information on the locked door policy on the entrance/exit to the ward, however, on

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[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

this visit it was not visible. We suggest that this be reinstated to ensure that everyone using the service was aware of the policy.

Advocacy services were mostly provided by Borders Independent Advocacy Service (BIAS) and this was available to all individuals.

In one of the files we reviewed, we noted that the person was designated as being on enhanced engagement, but there was no specific definition for this, and it was only described as "staff being aware of the individual's whereabouts on the ward". We suggested that if, due to an individual's presentation they required more intensive input, then a more formal framework should be put in place to identify the person's specific needs and how these would be supported.

When we are reviewing individual's files, 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 is 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 found no advance statements for any of the individuals who were being treated under the Mental Health Act but note that this was likely due to the stage and progression of people's illnesses.

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

The activity co-ordinator provided activities five days per week. These mostly took place from Monday to Friday, but we were told that occasionally activities were arranged at the weekend.

The activities varied in content, depending on the interests and abilities of the people who were in the ward. Where possible, all staff were involved in the providing activities. On the timetable of the week of our visit, activities included hand massage, games aimed at helping mobility and coordination, and outings, where appropriate.

When an individual had participated in any of the activities, this was recorded in their continuation notes which indicated how well the individual had or had not been able to participate; this information was used to aid assessment. We found that the activities/occupation provided were meaningful and tailored to individual needs.

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

The physical environment

The ward was divided into two areas, ‘Garden’ and ‘Thistle’. Both areas had their own spacious sitting/dining area.

There were 12 bedrooms and the ones we saw were, where possible, personalised. The ward had recently been painted, and significant efforts were being made to make the environment welcoming and comfortable. We were told that although there were no pictures on the walls, money had been made available for this, and they were on order.

In our last three reports, we raised concerns about there not being enough bathing/showering facilities for everybody, which we consider is having a negative impact on privacy and dignity. We were told that this had now been assessed and costed, but that there was no provision in the current budget to carry out the work, even for one room. While we understand the financial pressures that health boards are under, a fundamental right to privacy and dignity is of paramount importance. As this has been highlighted on three occasions, we will repeat this recommendation but now consider that it needs to be escalated to the general manager/senior management for a response.

Recommendation 3:
The general manager must review the current bathing/showering facilities and provide a response as to how and when this work may be financed in order to uphold the right to privacy and dignity for individuals receiving care and treatment in the BSDU.

There have also been ongoing concerns about the risks in the garden area for several years and it was not easily accessible and safe for the people who were using it. We were pleased to hear that a successful application had been made for endowment funds and plans had been accepted but were reliant on the estates department completing their own assessment. We were told that if this assessment was carried out timeously, then work could begin within a few months of our visit. We would hope that this can be expedited.

In our last report, we raised concerns about signage in the ward, and we were advised that these were on order and was due to be put up the week after our visit. The signs that indicated the lounges and that directed individuals to bedrooms were in place. However, there was no personalised signage to help individuals locate their bedroom, only their name and in a few cases, some black and white photocopied pictures which did not really aid identification of their own rooms. It would help with orientation if this could be remedied with improved signage for bedrooms.

The BSDU was previously known as Melburn Lodge. Signage in the Borders General Hospital to inform visitors still referenced Melburn Lodge. We are aware that the estates department are under considerable pressure, however we would hope to see this changed at the earliest opportunity and certainly by our next visit.

There was a sensory room which had previously been a hairdresser’s room and still needed some work to make it functional. We were advised that this would be completed within a few weeks of our visit.

Summary of recommendations

Recommendation 1:

Managers should ensure that relatives/carers are routinely consulted prior to the MDT meeting and their views are recorded on the MDT meeting proforma.

Recommendation 2:

Managers must review the care plan audit process to ensure that the qualitative information contained in the care plans accurately reflects the nursing interventions required to meet the identified care need.

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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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