

**Mental Welfare Commission for Scotland**

**Report on an unannounced visit to:** Cauldshiels Ward,  
Borders General Hospital, Melrose TD6 9DS

**Date of visit:** 4 November 2016

## **Where we visited**

Cauldshiels is a 14-bedded mixed sex ward providing assessment and treatment for older people with a diagnosis of dementia. There were 12 patients on the ward on the day of the visit. We last visited the ward on 22 July 2015 on an announced local visit.

On the day of this visit we wanted to follow up on the ten recommendations made following the previous visit, and we also wanted to follow up on issues that had been raised during our unannounced visit to Lindean ward the week before. (Lindean is an adjoining ward for people with a functional illness, which sometimes takes the patients from Cauldshiels when Cauldshiels is full).

## **Who we met with**

On the day of the visit we met with nursing staff, the consultant psychiatrist attached to the ward and the nursing operations manager. We reviewed the care and treatment of eight people.

## **Commission visitors**

Moira Healy, Social Work Officer

Margo Fyfe, Nursing Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

#### **Multidisciplinary team (MDT) input**

There is one inpatient consultant psychiatrist on Cauldshiels and one outpatient consultant, who, in consultation with the ward consultant, refers patients on to the ward. We gained the impression that this arrangement worked well. Following on from last year's visit, we noted that there were excellent admission notes giving a very clear circumstances and support given to the patient prior to the admission and reason for admission. This information was very helpful in determining the future goals from this current admission. Information from the dementia liaison nurse within Borders General Hospital was also of a very high standard and informative. Communication and engagement with families was evidenced throughout the notes and MDT records. There is dedicated physiotherapy and occupational therapy (OT) provision to the ward. Speech and language therapy and dietetics is on a referral only basis. There was evidence of close involvement from all allied healthcare professionals throughout the notes. A number of the patients whose files we reviewed had complex physical health problems which were identified on admission and followed up rigorously during their stay.

MDT records and the weekly nursing reviews were of a high standard generally. However, there were times when the records did not indicate who was present during the MDT review, or initials rather than names were given. We would like to see this rectified.

### **Care plans**

The standard of care plans was disappointing, particularly as this was a recommendation following last year visits. Unfortunately, we saw no improvement from last year. Care plans should be person centred, individualised and reviewed on a meaningful basis at regular intervals. Unfortunately, the care plans did not meet this standard and reviews were often not meaningful.

### **Recommendation 1**

As a matter of priority, managers should address the standard of the care plans, ensuring they are person centred, individualised and reviewed regularly.

### **Use of mental health legislation**

On the day of the visit, four patients were subject to the Mental Health (Care & Treatment) Scotland Act 2003 (the Act). All patients were receiving treatment in accordance with the Act. Consent to treatment certificates (T2) and certificates authorising treatment (T3) were present in the medical files.

We noted one informal patient had been given two doses of intramuscular (IM) medication for agitation. We were very concerned about this practice, and passed on our concerns to the operational manager at the end of the day who will raise with the consultant in charge of the ward. Another two patients were written up for IM medication and although this had not been administered, the routine prescribing of this may breach somebody's rights under the Act.

In adult acute admission wards, administration of "if required" IM psychotropic medication almost always requires the legislative authority of the Mental Health Act. Therefore, we consider that IM "if required" medication should not be prescribed for informal patients, other than in exceptional cases where staff and a known patient are clear that it is for use in known circumstances where the patient expects they would consent to the treatment. Even then, staff and the patient should be clear that they can withdraw their consent at any time.

### **Recommendation 2**

Medical staff and the ward manager should review the practice of prescribing IM medications for informal patients. Managers should ensure that intramuscular "if required" psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances. This needs to be addressed immediately.

## **Use of incapacity legislation**

Section 47 certificates were in place in most files and most had an individual treatment plan in place. Unfortunately, some certificates had become detached from the treatment plan. It would be good practice if this legal authorisation for giving medical treatment for people who lack capacity was held in the medication folders along with the authority to treat people under the Act.

We were not always able to locate the legal paperwork in relation to people who referred to themselves as being a power of attorney. In addition to this, there was no space on the front sheet for identifying if a legal proxy decision maker was in place and who this might be. This information was recorded on the MDT sheet but not on the front sheet. The lack of legal paperwork is disappointing as this was raised during the last visit and we were assured that all registered nursing staff would receive information on the importance of recording this. This appears not to have happened.

### **Recommendation 3**

Managers should ensure all staff are aware of and understand the effects of a welfare guardian or power of attorney having been appointed as a proxy decision maker. Nursing staff should be aware of the necessity for production of copies of this legal paperwork, this should then lead to a discussion regarding delegation of powers which should be recorded in the notes.

## **Recreation and therapeutic activity**

We were pleased to see there was a wide range of activities available and happening within Cauldshiels ward. The appointment of a dedicated (temporary) OT technician on the ward within the last 12 months has made a significant and very important contribution to the care of people on the ward.

## **The physical environment**

The ward was clean, spacious and bright. Each patient had their own room with ensuite facilities. The patients' bedrooms were identifiable by large signs with the person's name and a pictorial image of an interest they once pursued. Toilet doors were also well signposted. However, there were no signs to identify the lounge and dining area or the location of toilets from this area.

The corridor walls in Cauldshiels were not as stimulating as perhaps they could be for this patient group. The use of colour schemes to help with orientation was also minimal. There was some written information attached to the walls which related to events during various decades from the last century. This was a good idea but there was far too much information written in very small type and there was no pictorial evidence to support the statements. We were told that funding had been secured for

major refurbishment of the environment, however the lack of progress since the last year was disappointing.

#### **Recommendation 4**

Managers should inform the Commission of progress regarding plans to improve the standard of the environment in order to make it more dementia friendly.

#### **Any other comments**

All staff were very helpful on the day of the visit and the atmosphere on the ward was calm. The patients looked well cared for and content.

Overall, the Commission visitors were concerned about staffing issues that were raised on this ward. We were told that there have been difficulties with maintaining morale and recruiting nurses.

We were also concerned that number of patients were waiting for a bed in Melburn Lodge, the continuing care ward, but were not able to access a bed there due to the number of patients who were waiting for the allocation of social worker to organise a discharge home or to a care home. We would like an update with regard to management of these situations as soon as possible.

#### **Summary of recommendations**

1. As a matter of priority, managers should address the standard of the care plans ensuring they are person centred, individualised and reviewed regularly.
2. Medical staff and the ward manager should review the practice of prescribing IM medications for informal patients. Managers should ensure that intramuscular “if required” psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances. This needs to be addressed immediately.
3. Managers should ensure all staff are aware of and understand the effects of a welfare guardian or power of attorney having been appointed as a proxy decision maker. Nursing staff should be aware of the necessity for production of copies of this legal paperwork, and this should then lead to a discussion regarding delegation of powers which should be recorded in the notes.
4. Managers should inform the Commission of progress regarding plans to improve the standard of the environment in order to make it more dementia friendly.

#### **Service response to recommendations**

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

**Mike Diamond**  
**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 MWC 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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