



Mental Welfare Commission for Scotland

Report on announced visit to: Borders General Hospital, Borders
Specialist Dementia Unit, Melrose, TD6 9BS

Date of visit: 23 April 2024

Where we visited

Borders Specialist Dementia Unit (BSDU) is a 12-bedded unit that provides assessment and treatment for individuals with dementia over the age of 69 in the Scottish Borders. On the day of our visit, there were 12 people on the ward.

We last visited this service in March 2023 on an announced visit. We made recommendations on carer involvement, recording and storage of clinical records, risk assessment, care plans, section 47 certificates, the environment, including signage, the garden and bathing/showering facilities. The response we received from the service was acceptable in most cases.

On the day of this visit, we wanted to follow up on the previous recommendations, review the progress and hear about the care and treatment that was being delivered.

Who we met with

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 activities co-ordinator and the art therapist.

On the last visit there were significant staffing vacancies, in particular the charge nurse posts were vacant. These have now been filled and there were two vacant staff nurse posts.

We met with and reviewed the care of seven people. We also spent time on the ward talking to individuals informally and met with two relatives.

Commission visitors

Susan Tait, nursing officer

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

The two relatives we met with were both extremely positive about the care their relative was receiving. They said they felt “fully involved, listened to” and when they raised any issues or concerns, these were acted on swiftly. They described the team as “respectful, caring and that nothing was too much trouble”. Importantly they both said they felt confident when “walking out the door” that their relative would be cared for in the way they wanted.

Whilst it was limited in the interaction, we were able to have a brief conversation with individuals on the ward, however due to the progression of their dementia, those that we spoke with were able to express views such as “the staff are lovely”, “the food is good and I like what there is on offer”. There was a calm atmosphere in the ward and we were able to see warm and caring interactions between individuals and staff.

We also met with the art therapist, who was on placement in the ward. They described the team as caring and always willing to “go the extra mile” for the people that they were caring for.

Care, treatment, support and participation

On the last visit, we made a recommendation about involvement of carers and relatives. On this visit, we were able to see that changes had taken place and there was evidence of relative/carer involvement, which was reiterated by the relatives we met with. This was in addition to the recording of family meetings, where the views of relatives had been considered at the weekly multidisciplinary team (MDT) meetings.

In our last report, we made a recommendation to ensure care plans were current, person-centred and regularly reviewed. On this visit, we were able to see that in most cases, this had been acted upon.

We noted that the care plans were holistic and identified strengths, as well as care needs. They were mostly descriptive of the delivery of the nursing interventions. In one instance we noted that where the care plan had identified changes required in the review, a new care plan had not been generated, which did not then reflect the current care needs. While it is important to note the progress that has been made since the last report, there were still improvements that could be made to ensure that the care plans are current and reflect accurately the delivery of nursing support. This would be achieved by applying robust qualitative audit.

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.

Recommendation1:

Managers should 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.

Each person had a whiteboard in their bedroom with information about the individual, detailing what mattered to them and what worked best if they were distressed. It also gave relatives/carers and the individual themselves an opportunity to write or draw anything they

wished to convey to staff. This worked well and helped new staff or those who were unfamiliar with the individuals; we found this to be a good example of collaborative information sharing.

At the time of our visit, there were five people who had been assessed as no longer requiring further NHS treatment and were awaiting care home placements. They were described as having a delayed discharge

Care records

NHS Borders used 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 and if they were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act).

While it was difficult in a number of cases to capture the individual's view of the care they were receiving, there was a section in the record of the MDT meeting that highlighted participation from individuals and relatives/carers. A nursing view on the individual's presentation over the previous week was also used to inform the update of the care that was being delivered. We were able to see that discharge planning was being considered at an early stage following admission, and the plans were comprehensive.

The daily continuation notes, which all disciplines contributed to, were descriptive of the individual's day, and included care needs and linked to care planning; relative/carers views were also incorporated. However, in one instance we noted that an individual had required physical restraint due to their levels of aggression and although this was recorded in the incident review, it was not commented on in the chronological notes, which then did not accurately reflect that individual's presentation.

In our last report we made a recommendation about ensuring information was legible and easily accessible, and we were pleased to see that this had been rectified and action taken to meet this recommendation.

We also made a recommendation about risk assessments and risk management plans. On this visit, we were able to see that this had been fully implemented as all the files we reviewed had a current risk assessment in place, along with risk management plans where required. The 'Ayrshire Risk Assessment Framework' (ARAF) was used in the BSDU.

Multidisciplinary team (MDT)

The MDT is comprised of nursing staff, including a SCN, two charge nurses, a consultant psychiatrist, who worked two half-day sessions per week, one full time activities co-ordinator and the recent addition of a care manager, who had been proactive in facilitating discharges from the ward. There was a physician associate doctor, who has significant input to the physical health care of all individuals on the ward. Through a referral process, there was access to physiotherapy, speech and language therapy, and social work, and all individuals who were subject to Mental Health Act detention had a mental health officer (MHO) allocated. We were told that there was no current access to occupational therapy (OT), however a new OT lead had recently been appointed and they would be reviewing the situation.

Our last report made a recommendation about the lack of psychology input to the ward and advised that this should be reviewed. There was still no access to psychology, although we were told that a scoping exercise was ongoing. This continues to leave a significant treatment gap, as many of the individuals who have been admitted to hospital required input and treatment for stressed and distressed behaviours. The current care team provides input where possible, but the specialist overview from psychology was not available.

Recommendation 2:

Managers to provide an update on the scoping exercise for psychology input to the ward and to review how psychology provision may be facilitated

The weekly MDT meetings discuss and plan care, including the individuals' views, which were incorporated whenever possible, along with relative/carer views where available and appropriate. Where there were family meetings indicated, the consultant psychiatrist met with individuals and their relatives/carers on admission to the ward. We noted that while every endeavour was made to ensure this happened, the consultant's time was very limited (two half days per week).

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health Act. All legal documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (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. None of the individuals detained had yet met the timeframe threshold for T2/T3 certificates being required.

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 were incomplete, with some dates not inserted where required. This was discussed on the day of the visit and was rectified on the day.

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

Rights and restrictions

The ward operated a locked door policy that was commensurate with the risks associated with the individuals in the ward. There was clear information on the locked door policy on the entrance/exit to the ward.

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

Activity and occupation

The activity co-ordinator provided activities five days of the week. These varied in content, depending on interests and abilities of the people who were in the ward. One individual had a very structured programme, which was tailored to their individual needs. We were shown a video which had been made, and helped provide information about the activity co-ordinators role, and what could be offered. Where possible, all staff were involved in the provision of activities.

On the timetable of the week of our visit, activities included hand massage, games which were aimed at helping mobility and coordination, and outings, where appropriate. We had noted in the last visit that the activity programme on the wall was very small and difficult to read; this had now been replaced by a much larger one.

The physical environment

In our last report, we raised concerns about signage in the ward and we were advised that this was on order and was due to be put up the week after our visit.

The ward was divided into two parts, and both areas had their own spacious sitting/dining area. The bedrooms we saw were personalised, where possible. One individual had been able to bring in some small pieces of their own furniture. We had previously observed that some unused rooms could be used more effectively, for example, the hairdresser room that was being used for storage. The sink was due to be removed and thoughts had been given to how this room could be used more therapeutically.

The enclosed garden had raised flowerbeds and in our previous report we noted that there were some plants that were toxic if eaten. These had been removed, but the garden remained in much the same state as the last visit, with uneven ground. We were told that funding had been applied for and that the head gardener attended fortnightly meetings to provide an update. We look forward to seeing the changes during our next visit.

In our last two reports, we have raised concerns about there not being enough bathing/showering facilities for all patients, which we consider has an impact on privacy and dignity. We were told that the estates department had measured the rooms but there had been no update. Whilst we understand the financial pressures that health boards are being placed under, a fundamental right to privacy and dignity is of paramount importance.

Recommendation 3:

Managers must undertake a detailed review of the bathing/showering facilities in order to ensure that the service is upholding each individual's right to privacy and dignity.

Summary of recommendations

Recommendation 1:

Managers should 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.

Recommendation 2:

Managers to provide an update on the scoping exercise for psychology input to the ward and to review how psychology provision may be facilitated.

Recommendation 3:

Managers must undertake a detailed review of the bathing/showering facilities in order to ensure that the service is upholding each individual's right to privacy and dignity.

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 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777

Fax: 0131 313 8778

Freephone: 0800 389 6809

mwc.enquiries@nhs.scot

www.mwcscot.org.uk

