Mental Welfare Commission for Scotland

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

Date of visit: 28 and 29 October 2024

Where we visited

Huntlyburn House is a 16-bedded unit that predominantly provides acute mental health care for adults aged 18-69 in the Scottish Borders. This visit was carried out over two days. The first day was dedicated to meeting with those individuals who were in the ward at the time, and on the second day we met with more people who want to speak with us and their relatives. We met with staff and reviewed the care records.

On the day of our visit, there were 11 individuals on the ward.

We last visited this service in November 2023 on an unannounced visit and made recommendations on the audit of care plans, the rights of individuals in relation to their legal status and the recording of continuous interventions.

The response we received from the service indicated that they had completed or were in the process of completing their action plan in response to the recommendations.

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

Who we met with

We met with nine people and reviewed six sets of care records. We also met with two relatives.

We spoke with the service manager, the senior charge nurse, the associate medical director, the associate nurse director, the clinical aromatherapist and other nurses on the ward.

Commission visitors

Susan Tait, nursing officer

Anne Buchanan, nursing officer

Sandra Rae, social work officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

For this visit, the engagement and participation officer (lived experience) visited the ward on the 28 October and met with seven individuals who gave their views of the care and treatment they received.

Individuals had a positive view of Huntlyburn House and staff, which was reflected in their comments. We heard “the staff are good with talking with my husband; I am glad I came here, if I had stayed at home things would have got worse”, and “the nurses are good – they look after you, you can speak to them when you want, and they reach out to me when I can’t speak”.

We also heard that “staff are very kind and very understanding, nothing is a problem and you can ask them anything at any time of the day or night” and “staff are like a blanket around me, and I feel safe”.

We also heard positive comments about the activities on offer, the environment and the hospital grounds.

Care, treatment, support, and participation

Care records

The electronic system ‘EMIS’ is used in NHS Borders. We found this easy to navigate. The service kept all care plans in paper version, and they were uploaded to EMIS at the end of the episode of care. The service used the Ayrshire Risk Assessment Framework (ARAF), which was accessible on EMIS, as were the daily continuation notes.

In the continuation notes, we noted that the quality of recording was variable; there were some which gave a detailed picture of how the individual’s day had been, including what they had done and a self-report on how the person was feeling. We were able to see that staff had positive relationships with individuals, and there was a sense of commitment to providing person-centred care.

However, in others there were entries containing statements such as, ‘evident around the ward’ and ‘low profile on the ward’. These statements gave a limited understanding of how the individual presented.

Recommendation 1:
Managers should consider training to ensure the quality of recording in continuation notes reflects the individuals mental state and clinical presentation.

Care plans

When reviewing the nursing care plans, we noted that some had been discontinued but had not been removed from the active file; this could lead to confusion for both nursing staff and individuals. We also found the quality of these to be variable.

Some resembled a tick list of things to do, such as refer to social work, physiotherapy, etc. and while this is important, it did not reflect the detail of nursing interventions that would be needed to support the individual in the care and treatment of their mental ill health.

Others gave good examples of interventions, such as helping an individual to use distraction techniques which were unique to them when they were distressed.

Care plans were reviewed but did not always reflect the stage the person was at in achieving the goal that they had set for their recovery. The record only noted that the care plan remained the same. We were disappointed to see this, as both audit and quality of care plans have been regular recommendations since 2019. As a result of the limited improvement in this area, we have escalated our concerns to the associate nurse director.

Recommendation 2:
Managers must review the current audit for nursing care plans to ensure that they are person centred and SMART (specific, measurable, achievable, reviewed and timely) and reflect individual participation, where possible.

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.

Multidisciplinary team (MDT)
The MDT comprised of nursing staff, psychiatrists, an activities co-ordinator, a clinical aromatherapist, an exercise specialist and social workers with mental health officer qualifications (when required).

Referral could be made to dietetics and physiotherapy, although we were told there is a current vacancy for physiotherapy.

The ward was fully staffed of nurses, but there continued to be challenges in recruiting adequate medical cover.

On the last visit it was noted that three hours of clinical psychology time had been allocated to the ward, but at that time we were unsure how this could be used for individuals who would need this to address their mental health recovery and wellbeing. This was withdrawn and we were advised that it was considered that it was not viable to attend three MDT meetings. There was however some psychological therapy input to the ward, as some nurses were trained in delivering specific interventions, such as 'decider skills supervised by the consultant psychologist. We were told that the consultant psychologist was now available to do

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

assessments on request, which is important, however where specific clinical psychology was ascertained as necessary there was no funding identified for this.

We were told that the clinical psychology service was undergoing a review. Psychology input to inpatient services has featured as a note of concern within NHS Borders for the last few years.

We understand that an SBAR (situation, background, assessment, recommendation) communication tool had been completed by the psychology service for submission to senior managers. The Commission will also raise this with senior managers.

Recommendation 3:
Managers should conduct a service wide review of psychology to ensure equity of access across all mental health services.

The MDT meeting took place on a weekly basis and the proforma used for these meetings contained detailed information from nursing staff on the individual's progress in the week preceding the meeting and any discharge planning. There were also prompts on the document that highlighted when a review of specific aspects of care, including the review of treatment certificates, were needed.

Individuals were able to attend the meeting if they wished and if not, then nursing staff or advocacy were able to pass on any issues they wanted to raise and feedback on this.

Use of mental health and incapacity legislation

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

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment, were located with the medication prescription sheets.

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 for five of the seven individuals. We found two instances where a T2 or a T3 certificate did not authorise the prescribed medication. This was brought to the attention of the responsible medical officer (RMO) on the day.

We would have hoped that the proforma which was being used at the MDT would have picked up on these discrepancies. Senior managers told us that they would review this.

Recommendation 4:
Managers and clinical staff should ensure that all psychotropic medication is legally 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 being treated under the AWI Act, we found that all section 47 certificates were completed appropriately.

Rights and restrictions

Huntlyburn House allowed for free egress. The front door was locked for entry, although there was access via the back door which led to the garden and grounds.

All doors were locked at night for security reasons.

In our last report, we asked that the rights of individuals were made clear to them and in particular, whether they were detained under the Mental Health Act or not.

During discussions with some individuals, they were unsure if they were detained. It may be helpful for staff to discuss this with individuals when preparing and completing the MDT meeting proforma. This should ensure regular discussion with individuals and should support a clearer understanding of their detention status and their rights in relation to this.

Recommendation 5:
Managers should ensure that individuals in Huntlyburn House are aware of their detention status, and that these discussions are recorded in the care records.

When we are reviewing individual's files, we look for copies of advance statements. The term 'advance statement' refers to a 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 did not find any statements in place, although information was available. Referral was made to local advocacy service, as and when required.

The Commission has developed *Rights in Mind.*[2] 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.

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

Activity and occupation

Huntlyburn House had an extensive range of activities available that included ward-based activities and outings to the local community. There was an activities co-ordinator in place and their addition had enhanced an already well-established programme.

The morning usually started with a group meeting called 'positive steps', which was attended by staff and individuals. The planning for the day was based on what individuals wanted to do and what was available that day. When we visited, it was near Halloween and there had been a shopping trip for pumpkins, followed by the carving of them and plans to make soup from them the next day.

There was a gym, with new equipment which was used by individuals who were assessed as suitable to use it. This was usually under the supervision of the exercise co-ordinator and referral to physiotherapy, if necessary. Tai chai, gardening in the large garden (which was called 'space to grow') and other creative activities were offered. Aromatherapy was available once per week. Outdoor walking was usually planned for each day (weather dependant) and there were bikes available for cycling.

There were quiet spaces around the grounds for people to access, and some chose to practice mindfulness in these areas.

Huntlyburn House provided exemplary occupation and activities opportunities, which aided the recovery and well-being of individuals

The physical environment

The layout of the ward consisted of individual ensuite bedrooms where people could bring in personal items should they wish to do so. There was a sitting dining room with access to tea/coffee/snack making for individuals.

The ward was bright and clean although there was some ongoing repair work taking place in some of the bedrooms.

The entrance to the ward had information on various organisations that offered help and support. The garden was accessible to all and was reasonably well kept. There was also a large separate room which could be used to facilitate family and children visiting, with a pool table, books and various activities for people to use.

The ward had a calm, welcoming and peaceful atmosphere at the time of our visit and one individual commented how this aided their recovery.

Summary of recommendations

Recommendation 1:
Managers should consider training to ensure the quality of recording in continuation notes reflects the individuals mental state and clinical presentation.

Recommendation 2:
Managers must review the current audit for nursing care plans to ensure that they are person centred and SMART (specific, measurable, achievable, reviewed and timely) and reflect individual participation, where possible.

Recommendation 3:
Managers should conduct a service wide review of psychology to ensure equity of access across all mental health services.

Recommendation 4:
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Recommendation 5:
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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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