Mental Welfare Commission for Scotland

Report on announced visit to:
Borders General Hospital, Lindean Ward, Melrose, TD6 9BS

Date of visit: 8 September 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

Lindean Ward is a six-bedded, mixed-gender ward providing assessment and treatment for adults aged 69 years plus, with a mental illness. It is based in Borders General Hospital

We last visited the service in July 2023 and made recommendations in relation to care plans, do not attempt cardiopulmonary resuscitation (DNACPR) forms, section 47 forms, activity provision, and environmental concerns.

On the day of this visit, we wanted to follow up on the previous recommendations and to hear from individuals and staff about the care and treatment in the ward.

There were six individuals in the ward, and we met with four of them and reviewed their care records. We also spoke with two relatives.

We spoke with the senior charge nurse (SCN), charge nurse, ward staff, clinical nurse manager, the general manager, the associate physician and the consultant psychiatrist.

Commission visitors

Susan Tait, nursing officer

Tracey Ferguson, social work officer

What people told us and what we found

All the individuals we spoke with were very positive and complimentary about the care they received from all of the multidisciplinary team (MDT) and we observed respectful and kind interactions between nursing staff and individuals.

We were told that there were no nursing vacancies, and the ward had a stable team of staff.

The relatives we spoke with said that they felt there was good communication with the ward team and were happy with the care their relative was receiving.

Care, treatment, support, and participation

We noted that one of the individuals was 'boarded' from the Borders Specialist Dementia Unit as there was pressure on admissions for that service and although this is never the best option for people with differing needs, we recognised the difficulties that services experience and that significant efforts had been made to provide a 'dementia appropriate' approach to their care. We highlighted this in the last report and heard that it had happened on other occasions.

In one of the records 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.

Recommendation 1:
Managers should review the practice of 'enhanced engagement' and formalise the practice and definition. If a person requires more intensive input, then this intervention should be detailed in a care plan.

Care records
NHS Borders continued to use the electronic system EMIS which was reasonably easy to navigate and had all the pertinent information available.

The risk assessments were completed on admission, at three-month intervals and again on discharge. Safety care plans were reviewed daily and adjusted appropriately if the risk changed.

The care plans we reviewed were detailed, person-centred and descriptive of nursing interventions. The reviews were timely and thoughtful, although changes to care and treatment were not always reflected in the care plan. There was a trial of 'doodle care plans' which did not require a great deal of writing and there was clear evidence

of individuals' involvement in their care where possible. It was clear that the previous recommendation regarding audit had been met and improvements had been made.

The continuation notes were of a good standard, describing how the individual had presented and what their day had entailed. Where discussions took place with the person, these were well documented.

Multidisciplinary team (MDT)
There was good recording of the MDT meetings that took place weekly and where care and treatment were reviewed. There was a record of attendance and the meetings had a holistic focus, including the individual's view and had relative/carer input, with clear outcomes recorded from the meeting. Separate family meetings also took place.

We noted that there was comprehensive overview of person's physical healthcare needs. The service employed an associate physician, whose sole responsibility was around physical healthcare. We met with the associate physician on the day and discussed the value this brought to older people. We were pleased to hear that psychology was now part of the MDT.

Use of mental health and incapacity legislation

On the day of the visit no one was detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). A presumption is then made that individuals had consented to their admission. If there was a change in their presentation or risk, this would be reviewed by the consultant psychiatrist or duty doctor.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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.

In the last report we raised concerns about the lack of oversight of section 47 certificates and DNACPR certificates. On this visit we were pleased to see that the previous recommendations had been met and all documentation relating to the AWI Act, including certificates around capacity to consent to treatment were easily accessible and that these were now reviewed weekly at the MDT meeting.

Rights and restrictions

The ward had a locked door, with a locked door policy displayed at the entrance. The people we spoke with were able to say they would just ask a member of staff if they wished to leave. When we arrived at the ward door, we were able to look directly into

an occupied bedroom; all the bedrooms were the same. The path past Lindean Ward is a throughfare for members of the public. We were concerned that this could compromise people's dignity and right to privacy if they were unwell and unable to protect this for themselves. We would suggest that privacy screening is put in place, which would allow individuals to see out of their rooms but not allow others to see in.

Recommendation 2:
Managers should arrange to have privacy screening applied to all bedroom windows to protect individual's privacy and dignity.

Most of the records we reviewed had a 'pass plan' which stated when to individual was able to leave the ward and whether they required staff to accompany them. While this is important information, there was nothing in the plans that indicated the person was in the ward on an informal basis or that they had agreed to these restrictions. We would suggest that the use of the language 'pass plan' indicates that an individual is detained.

Recommendation 3:
Managers should ensure that all restrictive practices have the appropriate level of consent or legal framework in place to underpin them.

The Commission has developed *Rights in Mind.*[1] 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

There were no individual activity programmes, but we noted that each day started with a 'positive steps' meeting and individuals discussed what they would like to do that day from a range of options including cooking/baking, walks, and art.

There was a nurse identified on each shift to co-ordinate the activities. While this would meet our previous recommendation of reviewing the activity provision, we heard that if there was a high level of clinical activity or if staff were moved to cover other wards, then this had a negative impact on the activities for the day. However, we were told that every effort was made to minimise this.

There was access to an exercise specialist, who provided active input tailored to an older population. We have suggested that there was a record kept of how often clinical need impacts on activities, which would support the need for a dedicated activities co-ordinator. The following recommendation has already been repeated

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

twice and although there is now a nurse identified for this each shift, we would like to hear what managers plan to do to improve the situation.

Recommendation 4:
Managers must review the activity provision with a view to having a consistent activity co-ordinator for the ward.

The physical environment.

The ward was spacious, bright and clean with a welcoming atmosphere.

An individual showed us around their bedroom. They showed us specific ligature points throughout the room and commented “should I wish to hang myself it would be easily done… thankfully I don’t but others might”. They also pointed out that there was a significant gap in the window frame allowing cold air to enter. We raised this issue regarding the window at the end of day meeting and the general manager asked that this was escalated to them immediately to have this repaired.

On the last visit, we again made recommendations to review the lay out of the ward and had ongoing concerns about the shower/bathing facilities. There was still only one bath/shower room between six patients of mixed gender. This continues to be an unacceptable position for people, particularly if they have a lengthy admission.

We were told that there was frequent flooding from the ward above Lindean Ward, which regularly put the bathroom out of commission until water was cleared up. The tiles on the ceiling in the bath/shower room and in the corridor outside the room were badly stained.

In relation to the layout of the ward, nothing had changed. Individuals were still unable to have appropriate access to facilities that would support independence, including access to the kitchen and washing machine. Due to the placement of these areas, and the proximity to staff areas and outpatient clinics, staff always had to be present. This could be overcome by blocking off an area that would then ensure people were able to maintain their independence and sustain their skills where possible.

The kitchen was in the same state as two years ago, with the cupboards and drawers all having the laminate peeling away. We were told that there was a significant backlog of jobs sitting with the estates department. However, this should not deter managers from urgently reviewing the situation and seeking solutions. All other areas of the ward where individuals accessed were clean and comfortable, and people were able to have their personal possessions in their bedrooms.

Recommendation 5:
Managers must urgently review the environment in Lindean Ward, paying particular attention to anti-ligature work, appropriate bathing and kitchen facilities.

Summary of recommendations

Recommendation 1:
Managers should review the practice of 'enhanced engagement' and formalise the practice and definition. If a person requires more intensive input, then this intervention should be detailed in a care plan.

Recommendation 2:
Managers should arrange to have privacy screening applied to all bedroom windows to protect individual' privacy and dignity.

Recommendation 3:
Managers should ensure that all restrictive practices have the appropriate level of consent or legal framework in place to underpin them.

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Recommendation 5:
Managers must urgently review the environment in Lindean Ward, paying particular attention to anti-ligature work, appropriate bathing and kitchen facilities.

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.

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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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