Mental Welfare Commission for Scotland

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

Date of visit: 21 May 2026

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

Huntlyburn House is a 19-bedded, mixed-sex unit that predominantly provides acute mental health care for adults aged 18-69 in the Scottish Borders. On the day of our visit, there were 11 individuals on the ward and eight empty beds.

We last visited this service in October 2024 on an announced visit and made recommendations on the audit of care plans, the quality of daily notes, a review of the psychology service, the authorisation of psychotropic medication and the rights of individuals in relation to their legal status.

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 and to hear from individuals receiving care and treatment.

Who we met with

We met with nine people and reviewed the care records of six. We also met with a relative.

We spoke with the senior charge nurse (SCN), nursing staff, the clinical nurse manager (CNM), the clinical psychologist, advocacy staff and we met with the general manager.

Commission visitors

Susan Tait, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

All individuals who were receiving in care and treatment were very positive about the input they had.

We heard comments from those that we spoke with that staff were approachable, were caring and "went the extra mile" to provide support. One person said that they had experience of care in different wards throughout Scotland and described Huntlyburn House as the best ward they had been in.

Care, treatment, support, and participation

Care records

The electronic system 'EMIS' is used across NHS Borders and we found this easy to navigate.

The service kept all care plans, which it now calls support plans, in paper version, and these were uploaded to EMIS at the end of the episode of care. We were made aware that there was no option to create support plans on EMIS; if this was available, handwritten plans, which at times were difficult to read, would no longer be required. We asked that the service contact the IT dept to explore the possibility of having this option available on EMIS.

Huntlyburn House uses the Ayrshire Risk Assessment Framework (ARAF), which was accessible on EMIS. We were unable to locate a risk assessment for one individual who was deemed as high risk and although there was a safety plan in place, we felt that a risk assessment was needed. We also found that other risk assessments had not been reviewed in a timely period; one had not been reviewed for over a year.

Recommendation 1:
Managers must ensure that every individual on the ward has a risk assessment in place, with a corresponding risk management plan and that these are regularly reviewed.

Overall, the daily continuation notes were much improved from our last visit, giving a good overview of the individuals' clinical presentation and their involvement in activities. There was still the occasional entry that provided limited information such as 'evident on the ward', which we felt was unhelpful and not descriptive of a person's clinical presentation.

We were able to see that staff had positive relationships with individuals, and there was a sense of commitment to providing person-centred care.

Care plans
The service had decided to rename care plans as support plans as it was considered that this more accurately reflected the purpose of the plan; to support the individual to attain better mental health.

We found that there had been a lack of improvement in the quality of the plans since our last visit; we had been advised that this had been addressed by input from the associate nurse director. The majority of the plans were vague and basic, with very little depth of information. While it was clear that the delivery of care and support was of a high standard, the documents that should reflect this were not of the same standard, despite an audit system being in place.

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.

Recommendation 2:
Managers must urgently address the support plans to ensure they meet the needs of individuals in the ward and adequately reflect the care and treatment being delivered.

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

Referrals could be made to dietetics and physiotherapy, if appropriate. The advocacy service also attended the MDT meeting when required.

The ward had a full complement of nursing staff, but there continued to be challenges in recruiting adequate medical cover and the current responsible medical officer (RMO) was a locum.

We were pleased to meet the newly appointed clinical psychologist, who was a welcome addition to the MDT and who was planning to provide one-to-one therapy, formulations and reflective practice sessions for nursing staff.

The MDT met weekly and individuals were invited to attend the meeting, if they wished to do so. Relatives could also be invited, although the relative we spoke with suggested that as the time of the MDT meeting occurred in working hours, it was difficult to attend and suggested that online invitations, via 'MS Teams' could be utilised. This was fed back to the team at the end of day meeting and was met with a positive response.

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

There was a comprehensive pro forma used for the MDT meeting which covered all aspects of care and was completed to a high standard.

Use of mental health and incapacity legislation

On the day of the visit, there was one person detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

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. At the time of our visit, the criteria for any treatment certificates had not been met for the individual, so none were required.

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.

We met with one individual and reviewed their notes. Following this, we asked that the person was reassessed for capacity in relation to giving their consent to medical treatment.

Rights and restrictions

The ward operates an open door for egress and a buzzer system for access on the front door. The back door was open for both.

Following on from a Fatal Accident Inquiry (FAI), where the court had one recommendation to make on the entry and exit to Huntleyburn Ward being controlled, full consideration was given to this. While the inference was strongly in favour of locking the door, this was never explicitly recommended. Following on from the inquiry, there have been extensive discussions at a senior level in NHS Borders, which have latterly also included the Commission.

While initially, the ward made changes that took into account the recommendation, this created difficulties for the individuals in the ward. A considered decision was taken to revert to free egress from the ward, unless a specific risk was identified. On the day of this visit, we were advised that plans were in place to provide the same system to the back door to provide a higher level of safety.

When we are reviewing individuals' 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 did not find any advance

statements, although on the MDT pro forma, it was noted whether an individual had one or not. We suggested that it is also important that any discussions about the promotion of these was recorded.

Several of the people we met with and who were consenting to their stay on the ward were unsure of their 'pass plan' and whether they were able to leave the ward if they wished to do so. We were concerned to hear that people who were admitted informally did not know that they were not compelled to remain on the ward and had they known this, may not have consented to this level of restriction.

We highlighted the importance of ensuring that everyone is aware of their legal status and the implications of this. We advised that that it should be explicitly set out and recorded that this information had been discussed with individuals and that there had been a full discussion if any changes were made.

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 and we suggested that this could be displayed prominently in the ward.

Recommendation 3:
Senior managers should ensure that every individual in the ward is aware of their legal status and the rights afforded by this, and that any restrictions placed on people are proportionate, fully discussed, recorded in the care records and consented to, as appropriate.

Activity and occupation

Huntlyburn House had an extensive range of activities available; these included ward-based activities and outings to the local community. There was a new activities co-ordinator in place and the addition of this post 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.

There was a gym, with extensive equipment which was used by individuals who were assessed as suitable to use it. This was usually under the supervision of the specialist 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

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

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. One individual we spoke with said that they valued the activities on offer and felt that they would benefit from a slightly more structured projection of what was happening over the week. We discussed this at the end of day meeting and the SCN said that they would meet with the activities coordinator to review.

We were pleased to find that Huntlyburn House continued to provide 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 and snack making for individuals.

The entrance to the ward had information on various organisations that offered help and support. We suggested the development of QR codes for quick access to pertinent information.

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.

All areas were bright and clean; the ward had a calm, welcoming and peaceful atmosphere.

The ward did not have full anti ligature status as doors in the bedrooms could be and had been used as ligature points. We were advised that funding had been agreed for this work to begin with an expectation that it would be completed in this financial year.

Summary of recommendations

Recommendation 1:
Managers must ensure that every individual on the ward has a risk assessment in place, with a corresponding risk management plan and that these are regularly reviewed.

Recommendation 2:
Managers must urgently address the support plans to ensure they meet the needs of individuals in the ward and adequately reflect the care and treatment being delivered.

Recommendation 3:
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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.

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

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