Mental Welfare Commission for Scotland

Report on unannounced visit to:

East Brig, Borders Mental Health Services, Tweed Road, Galashiels TD1 3EB

Date of visit: 21 July 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

East Brig is a 12-bedded, mixed-sex ward providing rehabilitation for patients in the Scottish Borders. It is situated in the town of Galashiels.

We last visited the service on 10 April 2019. The recommendations we made in the last visit were around care planning, the remit of the ward and the catering budget. On the day of this visit we wanted to follow up on the previous recommendations and also to hear how patients and staff have managed throughout the current Covid-19 pandemic.

Who we met with

We met with and reviewed the care of four patients. We spoke with the staff nurse in charge of the ward on the day of the visit, the clinical nurse manager and the responsible medical officer (RMO). At a later date we spoke with the senior charge nurse.

Commission visitors

Susan Tait, nursing officer

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

When we met with the patients, their overall view of the care they received was positive. One patient told us they felt well looked after, that staff were approachable and offered much encouragement in terms of rehabilitation. We were impressed by the positive attitude of the nurses we met; they knew the patients well and appeared to be invested in a recovery-focussed approach.

We saw that physical health care needs were being addressed and noted the comprehensive input from the associate physicians and the healthcare coordinator.

The care plans we looked at had clear goals, specific interventions and there was evidence of regular review. We noted one patient had significant communication problems, and the communication aid 'Talking Mats', had been used to facilitate participation in their care. Unfortunately, participation was not as evident in other care plans and it was difficult to see where patients had been involved in their care if they chose to be, or declined if they did not wish to participate.

We were shown a new form of integrated care plan which was very detailed and gave a comprehensive overview of the individual and plans for treatment and discharge. This had not yet been rolled out throughout the ward for all patients but we were assured that this should be in place over the next few months.

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, and can be found at:
https://www.mwcscot.org.uk/node/1203

One of the recommendations from our last visit was to review the function of the ward. We were concerned about the impact on the rehabilitation process for patients when the ward was also admitting patients who had an acute presentation of their illness, simply because they were known to the service. We had an opportunity to discuss this with the RMO who, alongside the SCN, has overall responsibility for deciding who should be admitted. Their view was that acutely unwell patients were more likely to have a quicker recovery in an environment with which they are more familiar. We acknowledge that this is a very valid view but emphasised that the service should keep this under to review to ensure that the mixed-ward function is not having a negative impact on the rehabilitation process for patients. We were told a new service is being developed jointly between NHS Borders and the third sector organisation, Carr Gomm; it is anticipated that this will provide a service for individuals who need longer episodes of rehabilitative care and this service is due to be open by January 2023.

Recommendation 1:
Managers should ensure patients participation in their care and treatment is recorded in their care plans.

Multidisciplinary team (MDT)

The ward has a broad range of disciplines involved, including occupational therapy, physiotherapy, psychology, nurses and psychiatrists. NHS Borders is piloting a new medical model using associate physicians. These staff are significantly involved in physical health monitoring and work alongside the physical health coordinator.

MDT meeting notes were very detailed, however it would be helpful to document who attended each meeting, in order to record which staff were involved in making decisions about clinical care. There was space for patients to give their view, but in the notes we looked at, this was rarely completed. We were unable to find clear discharge planning information in the MDT meeting notes and spoke with staff on the day of the visit about ensuring this is included in the meeting note. We were concerned to hear of the difficulty in obtaining social work input for the ward. We were told that the locum social worker who was allocated to provide social work assessment, carry out specific liaison with social work and third sector organisations, seek appropriate tenancies and packages of care, has been working remotely and is located a considerable distance from the service. Although it is acknowledged that remote working is much easier now, it was difficult to see how this arrangement was suitable for the patient group, given the complexity of their needs and the requirement for robust discharge planning. This was also raised as an issue by the clinical team.

Recommendation 2:
Managers should review the social work provision to the ward to ensure that it fully meets the need of this complex patient group.

Care records

Information on patients care and treatment is held in both paper files and on the electronic record system EMIS. We raised some concerns on the day about the use of inappropriate language in the multi-disciplinary care notes.

Use of mental health and incapacity legislation

On the day of our visit, four of the nine patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The patients we met with who were subject to detention under the Mental Health Act had variable understanding of their detention status.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, 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.

We reviewed all four T3 certificates. Three of the four were in order and legally authorised the prescribed treatment, however one patient had been prescribed an 'as required' medication out with the authority of the T3. This had not been administered and the psychiatrist discontinued it on the day. We were told there was an audit tool in place and whilst we do not consider a recommendation is necessary in this instance, we suggested the T2/T3 compliance should continue to be closely audited.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

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 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. All section 47's were in place and authorised the treatment for health care.

Rights and restrictions

Advanced statements are written statements made under S274 and 276 of the Mental Health Act, and are written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility to promote advance statements. On the day of our visit, there were no patients with an advance statement, however there was information available for patients on making an advance statement.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

There was significant input from occupational therapy and physiotherapy. We were able to see that there was a wide and varied programme to support rehabilitation and recovery. There was a notable emphasis on the benefits of engaging with outdoor/nature. The ward has chickens in the garden which are tended to by the patients and seemed very popular. There were groups such as barefoot walking, forest walks and tai chi, all of which have an evidence base for positively impacting mental health. There were other groups focussing on life skills, positive physical health choices and coping skills. There were two rooms dedicated to leisure/ activities and also a laundry and kitchen where patients could use and re-learn skills. One of the recommendations from the last report was to review the catering budget, as it was inadequate. We were told that this had been reviewed and increased.

The physical environment

At the last visit we raised concerns about the public areas of the ward, describing them as clinical and not conducive to the rehabilitation function of the ward. We were pleased to see that in response to this there have been significant efforts to change it. The ward now has a welcoming and comfortable environment and was bright, clean and well decorated. One patient described it as "cosy and great." All bedrooms are able to be personalised and patients had many of their own possessions. There is a well-kept garden which patients can freely access.

Summary of recommendations

Recommendation 1:
Managers should ensure patients participation in their care and treatment is recorded in their care plans.

Recommendation 2:
Managers should review the social work provision to the ward to ensure that it fully meets the need of this complex patient group.

Good practice

The ward provides a welcome pack for patients being admitted. This includes toiletries and a comprehensive information file, which explains the function of the ward, what to expect and also gives information on rights, advance statements and signposting to support organisations. This information is also available throughout the ward.

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.

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