**Mental Welfare Commission for Scotland**

**Report on announced visit to:**

Borders Specialist Dementia Unit, Borders General Hospital, Melrose TD6 9BS

**Date of visit:** 7 March 2023

## Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the 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.

The Borders Specialist Dementia Unit (BSDU) was built initially as a specialist dementia care ward for patients with continuing care needs. At the time of our visit, the ward was divided into two areas, had six beds in each area and provided assessment and treatment for male and female patients with dementia, over the age of 69.

We last visited this service on 4 February 2020 and made recommendations around social work input, the use of treatment certificates relating to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act), input from occupational therapy (OT) and the bathing facilities. Since this visit, we were pleased to see that there is now specific input from social work and there is dedicated OT input. However, the bathing facilities remained unchanged.

## Who we met with

Prior to the visit, we had a virtual meeting with senior charge nurse (SCN) and the service manager. On the day of the visit, we spoke with SCN, the activities co-ordinator, the associate nurse director and the service manager. We heard that due to staffing vacancies, there had often been times the SCN, had to be included in the number of registered staff on shift, to ensure continuity and safe delivery of patient care, thus impacting on their senior role. However, we heard that there had been recruitment to one of the depute SCN posts which will support the leadership team moving forward. We also heard of the continued efforts around staff recruitment. The Commission recognises that this is representative of a national picture and we have written to the Scottish Government raising our concerns about the recruitment and retention of mental health and learning disability nurses as well as other professions within this remit.

We heard that the SCN was undertaking the Dementia Improvement Specialists Leads (DiSL) programme. This programme is run by National Education Scotland (NES) and is a training for trainer's programme with a focus on service improvement and change management. The area of service improvement which was being focussed on was family/carer involvement at the onset of admission.

During our visit we introduced ourselves and chatted with patients on the ward. We were able to elicit some views from patients about their care and treatment, but were unable to have in-depth conversations, due to progression of their illness. However, most patients appeared relaxed and content in the ward environment.

We reviewed the care of six patients and met with two relatives.

## Commission visitors

Susan Tait, nursing officer

Gillian Gibson, nursing officer

Alyson Paterson, social work officer

# What people told us and what we found

## Care, treatment, support and participation

The relatives we spoke with said that they enjoyed visiting the ward and were made to feel welcome. They described the nursing staff as wonderful, committed and caring and they did not want their relative moved from the BSDU, as they were very happy with the care being provided. We were however told that they did not feel as involved or consulted as they would wish to be in relation to care and treatment; this was despite them both being granted 'power of attorney' by their relatives, and therefore had the legal authority to be the proxy for involvement. Throughout the visit we saw caring and supportive interactions between staff and patients, and the ward had a sense of calm and the patients appeared content.

We noted that three people were deemed as delayed discharges, meaning that they were assessed as being clinically ready for discharge, but continued to occupy a bed, usually because of delays in securing a placement in a more appropriate setting. We were told that there was not any specific support for discharge into care homes, supported accommodation or own homes, which was potentially contributing to these delays. We were told there was a care home assessment team who worked separately from the BSDU and we think it would be helpful to have formal links to support and facilitate discharge from hospital.

**Recommendation 1:**
Managers should ensure and evidence that relatives/carers are involved and have input into care and treatment, where appropriate.

### Care records

NHS Borders operates the electronic care record system, EMIS and all clinical information was recorded here. Some information was printed out and kept in various folders. Whilst we recognised that this was to provide easy access to care plans and other pieces of information, this also brings with it a risk of miscommunication and out-of-date information being kept. An example of this being that day-to-day information regarding activities was handwritten and then scanned onto EMIS after approximately one month. The handwritten information was difficult to read and the way in which it was scanned, it appeared sideways on the screen. We were unable to understand why the activities co-ordinator could not make chronological entries in the day-to-day notes that were held on EMIS.

**Recommendation 2:**
Managers should consider improved ways of recording and storing patient care records to ensure they are accessible, legible and current.

We were able to locate forms where individuals had a power of attorney in place, were under a guardianship order or had been detained under the Mental Health Act, although they were not all filed in the same place.

We were unable to locate up-to-date risk assessments pertaining to mental health. We were told that the current risk assessment, the Borders Risk Assessment Tool (BRAT) was to be superseded by a new risk assessment tool that will be rolled out throughout the service. It is important to keep risk assessments and management plans up to date to reflect any changes in an individual's mental health presentation.

**Recommendation 3:**
Managers should ensure risk assessments and risk management plans are relevant and up to date.

### Nursing care plans

The nursing care plans we reviewed were variable in quality and presentation. All were person-centred, with some being more detailed than others. However, we observed information which was not relevant to the care plan and was out-of-date, an example being "patient is 71 year old who currently resides with their partner" this information was identified as a 'need'. This particular care plan was completed in 2020 and was actually related to bowel care. This was a similar picture in all the care plans we reviewed, and the information appeared to have been repeated by cut and paste format.

There was good information contained in care plan reviews, however reviews and changes were not reflected in the original care plans, and this in turn made these out-of-date and inaccurate. We were told that a peer review audit was in place, but we would suggest that a more robust process is put in place.

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:
PersonCentredCarePlans_GoodPracticeGuide_August2019.pdf (mwcscot.org.uk)

**Recommendation 4:**
Managers should review the care plan audit process to ensure that nursing care plans are up-to-date and accurately reflect identified needs and nursing interventions.

### Multidisciplinary team (MDT)

The MDT comprised of a consultant psychiatrist, (RMO) OT, physiotherapist, nursing, pharmacy, social work and an activities co-ordinator. There was also a pilot position of physician associate who had a significant focus on physical health care. It was disappointing that there is no psychology input for patients, in particular where individuals experience distressed behaviour or are in the early stages of diagnosis of dementia.

The MDT meeting took place weekly and was documented on both EMIS and printed out for folder. There was a list of attendees. There was always a nursing view of the patient, and where possible the views of the patient, but not always the individual who held POA.

**Recommendation 5:**
Managers should review the psychology input to the ward.

## Use of mental health and incapacity legislation

The section 47 certificates under the Adults with Incapacity (Scotland) Act 2003 (the AWI Act) that we reviewed were of variable quality and some did not record the prescribed treatment.

The Commission has published an advice note guide about section 47 certificates. It is designed to help nurses and other clinical staff understand about section 47 treatment certificates and what these are, for people with mental ill health, dementia or learning

disability, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2021-10/Scope-Limitations-S47_advice2021.pdf

**Recommendation 6:**
Where a patient lacks capacity in relation to decisions about medical treatment S47 certificates, and where necessary, treatment plans must be completed in accordance with the AWI Code of Practice (3rd ed.), and cover all relevant medical treatment the individual is receiving.

## Rights and restrictions

BSDU has a locked door policy commensurate with identified risks and to preserve the safety of the patient group. Advocacy services were available to all patients from Borders Independent Advocacy Service.

## Activity and occupation

We met with the activities co-ordinator who had devised a programme of varied activities. There was also a regular visit from 'elder flowers', who are trained professionals who dress as therapeutic clowns and interact with patients. This appears to be well received by patients. Only one person had an individualised activity plan and whilst it can be difficult to engage patients in activities, it is important that activities are targeted to individual likes and dislikes. There was a timetable of activities available on the wall of the sitting room. However, it was very small and it would be helpful to have it in a format that patients were able to read.

## The physical environment

Although there were some dementia-friendly signs around the ward, there was little in the way to help people orientate themselves to their own bedrooms. BSDU was spacious and there were several rooms that were not well used, for example, there was a hairdresser room that was now being used as storage.

Most patients had quite personalised bedrooms. We saw some bedrooms had 'white boards' to allow relatives, staff or patients to write information on them. This information would help the patients 'getting it right for me' dementia presentation.

We noted that there were inadequate tables and chairs for patients who wanted or were able to sit at a table for meals.

There was an enclosed garden with raised flower beds, that enhanced the area, although there were some plants in them which were toxic if eaten. The ground was very uneven, there was no shade and there were several trip hazards noted. Both issues were also raised by a relative.

In the last report we raised concerns about having enough bath/showers available for the number of patients, that had an impact on both privacy and dignity. We were advised that a review had taken place and concluded that adding further bath/shower facilities would potentially reduce therapeutic space. During this visit we identified areas which were not being used to their therapeutic potential and as all bedrooms had en-suite toilets, there may be a potential to have showers added. We would therefore like to see a detailed review of the current facilities.

**Recommendation 7:**
Managers should review the environment to ensure that dementia friendly signage is in place and all areas are dementia friendly, including the garden.

**Recommendation 8:**
Managers should revisit the review of the bathing/shower facilities.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure and evidence that relatives/carers are involved and have input into care and treatment, where appropriate.

**Recommendation 2:**
Managers should consider improved ways of recording and storing patient care records to ensure they are accessible, legible and current.

**Recommendation 3:**
Managers should ensure risk assessments and risk management plans are relevant and up to date.

**Recommendation 4:**
Managers should review the care plan audit process to ensure that nursing care plans are up-to-date and accurately reflect identified needs and nursing interventions.

**Recommendation 5:**
Managers should review the psychology input to the ward.

**Recommendation 6:**
Where a patient lacks capacity in relation to decisions about medical treatment S47 certificates, and where necessary, treatment plans must be completed in accordance with the AWI Code of Practice (3rd ed.), and cover all relevant medical treatment the individual is receiving.

**Recommendation 7:**
Managers should review the environment to ensure that dementia friendly signage is in place and all areas are dementia friendly, including the garden.

**Recommendation 8:**
Managers should revisit the review of the bathing/shower facilities.

## 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