Mental Welfare Commission for Scotland

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

Date of visit: 4 July 2023

Where we visited

Lindean Ward is a six-bedded, mixed-sex ward providing assessment and treatment for adults aged 69 plus, with a mental illness.

We last visited the service on 24 March 2022 and made recommendations in relation to care plans, participation in care, restrictive practice, activities and environment. We did not receive a response from the service, and this was addressed on the day of the visit.

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

Who we met with

We met with five patients in person, and reviewed the care notes of all six patients.

We spoke with the senior charge nurse, charge nurse, ward staff, clinical nurse manager and the consultant psychiatrist (RMO).

Commission visitors

Susan Tait, nursing officer

Dr Neha Bansal, ST 6 higher trainee

What people told us and what we found

Care, treatment, support and participation

The patients we spoke with were all positive about the care they received and praised the help they received from staff. Patients told us that they were able to speak with responsible medical officer (RMO) at the weekly meeting or at family meetings. They said that nursing staff were approachable. We observed warm and respectful interactions with patients.

There was evidence of participation by patients in the care they received.

We were pleased to hear that there was only one nursing staff vacancy, which was a significant contrast to other wards.

We noted that one patient's discharge was delayed awaiting appropriate accommodation, but this was being actively pursued by the social worker.

We noted that one of the patients was 'boarded' from the Borders Specialist Dementia Unit as there was pressure on admissions for that service and although this was never the best option for patients with differing needs, we recognised the difficulties that services' experience and significant efforts had been made to provide a 'dementia appropriate' approach to their care.

We reviewed the 'do not attempt resuscitation' (DNaR) certificates and were concerned that one was three years old and had been completed when the patient was very ill. The patient had since recovered and the certificate had not been reviewed. We also had concerns about the wording on another certificate, which did not give clear guidance to staff. We addressed both issues on the day with the RMO who agreed to rectify these immediately.

Recommendation 1:
Managers arrange for audit of all DNaR forms as a matter of routine to ensure they are current and reflect appropriate actions.

Care planning and documentation

In the files we reviewed, there were detailed nursing assessments that had been completed at the point of admission. Risk assessments had also been completed using the Borders Risk Assessment Tool (BRAT), which we were advised, was to be shortly to be replace by Ayrshire Risk Assessment Framework (ARAF); the service considered this to be more detailed, thorough, and better met the needs of the patients.

Overall, the nursing care plans were of a good standard, including recording of the patients input to the plan where possible. Some were task-orientated and listed actions rather than nursing interventions. However, the interventions that were in place were personalised and clear. The format of the care plans was helpful, as it gave prompts to consider how to achieve a good outcome and also looked at the strengths of the patients.

There was detailed information on the reviews of the care plans.

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

Recommendation 2:
Managers arrange qualitative audit of care plans to ensure consistency.

Multidisciplinary team (MDT)

There was good recording of the MDT meetings and who had attended, which took place weekly and reviewed the care of all the patients. The meetings had a holistic focus and included the patient view and had relative/carer input, with clear outcomes from the meeting. Separate family meetings also took place.

We noted that there was good overview of patient's physical healthcare needs. The service employed an associate physician, whose sole responsibility was on physical health. This was initially a pilot but has been found to be successful and is now ongoing, although the post was about to become vacant.

There was access to physiotherapy and OT and psychology but there were long waiting lists for psychology in particular.

Mental health and incapacity legislation

As all the patients on the day of the visit had an informal status, there was no paperwork from the Mental Health (Care and Treatment) (Scotland) Act, 2003 to review.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 (s47) of the Adults with Incapacity (Scotland) 2000 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. The section 47 certificates we reviewed varied in detail; some did not authorise the treatment prescribed.

Recommendation 3:
Managers to arrange audit of s47 certificates as a matter of routine to ensure treatment prescribed be authorised.

Rights and restrictions

When we review patients' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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 found an advance statement in a patient's file which was 13 years old and had not been signed or witnessed; this meant it did not conform to the Mental Health Act legislation, and while it was of importance that it was in the file notes, we suggested that when the patient was well enough the staff should discuss their advance statement with them, and whether they wished to revisit this.

Lindean Ward continued to operate a locked door, commensurate with the level of risk identified in the patient group. In the previous report from our visit, we had concerns about the lack of information for patients about their rights when they were in the ward on an informal basis and the door was locked. On this visit, we found information on the wall on how to exit the ward and on discussion that had taken place with patients, where they were able to articulate how they could leave the ward if they wished.

We also had concerns about how levels of observation and enhanced engagement were documented and implemented. On this visit, we were able to see it was clearly documented where a patient had been able to agree with a level of observation when they were of an informal status, and there was a care plan in place to underpin this.

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

In the last report, we noted that while there was evidence of patients participating in daily activities, there was no occupational therapy (OT) input, or an activities coordinator. We made a recommendation to review this situation; unfortunately, the situation remained the same.

There were no individual activity programmes, but we noted that each day started with a 'positive steps' meeting and patients discussed what they would like to do that day from a range of options. This was dependant on the nursing needs of patients on that day.

Patients commented that they enjoyed going out of the ward for visits to local areas, gardening, shopping etc. On the day of the visit, there was a 'brunch club' where patients had shopped for ingredients and then cooked them, which they said they enjoyed immensely. These were the kind of important events, which supported the patient's independence and wellbeing. When there were patients who required significant input due to ill health, then activities were reduced or even stopped, as nurses needed to direct care to this. Specific and protected roles for activity would prevent this from happening and supports both the inpatient stay and work towards discharge.

Recommendation 4:
Managers again review the staffing for activity provision with a view to how this could be implemented.

The physical environment

On the last visit, we 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-sex and on the day of the visit, the bath was out of commission. This continues to be an unacceptable position for patients, two of whom raised concerns about this; one said "you have to be up quick if you want to be first in the queue".

There was a safe garden that patients have access to and it was well-used.

In relation to the lay out of the ward, nothing had changed. Patients were still unable to have appropriate access to facilities that would support independence. This could be overcome by blocking off an area that would then ensure patients were able to maintain their independence where possible.

The kitchen, which we were told was not a patient area, although patients had some access to, was not in a good state of repair. The cupboards and drawers all had the laminate peeling away.

We were told that there is a significant backlog of jobs sitting with the Estates department. However, this should not deter managers from reviewing the situation and seeking solutions.

All patient areas of the ward were clean and comfortable, and patients had personal possessions in their room.

Recommendation 5:
Managers should again review the environment in Lindean Ward to ensure that all space is utilised to maximise patient areas.

Summary of recommendations

Recommendation 1:
Managers arrange for audit of all DNaR forms as a matter of routine to ensure they are current and reflect appropriate actions.

Recommendation 2:
Managers arrange qualitative audit of care plans to ensure consistency.

Recommendation 3:
Managers to arrange audit of s47 certificates as a matter of routine to ensure treatment prescribed be authorised.

Recommendation 4:
Managers again review the staffing for activity provision with a view to how this could be implemented.

Recommendation 5:
Managers should again review the environment in Lindean Ward to ensure that all space is utilised to maximise patient areas.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date the service receives the 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.

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