Mental Welfare Commission for Scotland

Report on unannounced visit to: Huntlyburn House, Borders General Hospital, Melrose, TD6 9BP

Date of Visit: 15 and 16 November 2023

Where we visited

As part of a series of visits to more rural adult acute inpatient admission wards, the Commission undertook an unannounced visit, commencing in early evening, and continuing into the morning of the following day, to better understand what activities were available, and how care and treatment was provided in settings that did not have the same access to facilities available in more urban inpatient units.

We visited Huntlyburn House which is located in the grounds of Borders General Hospital. The ward is a 19-bedded, mixed-sex ward that provides care and treatment for adults aged 18-69 with a mental ill health diagnosis. On the day of our visit, there were 14 occupied beds on the ward.

We last visited ward in February 2022, and made recommendations regarding care planning and restrictive practices. For this visit, we wanted to follow up on the previous recommendations and hear from patients and their carers and/or families.

Who we met with

When we plan a visit, prior notice is given to individuals and relatives of our intention to visit. Given that this visit was unannounced, we were unsure if we would have the opportunity to speak with individuals and relatives, however we managed to speak with three individuals and we reviewed the care and treatment of five people. We also attended the community meeting that took place on the following morning with a further eight individuals.

We had the opportunity to meet with a range of staff, including nursing, the physiotherapist, the activity coordinator, the operational manager and the general manager.

Commission visitors

Susan Tait, nursing officer

Claire Lamza, executive director (nursing)

What people told us and what we found

Care treatment support and participation

The individuals we talked with were all very positive about the care they were receiving. We heard that "there's always someone to talk to" and "they let you get on with things in here". Those that we spoke with told us that they were able to "get out and about", that they could see the doctor to discuss what they needed and that "they are all quite great". The engagement that took place at the community meeting was also positive, with individuals sharing their goals for the day, enjoying some tea and biscuits while supporting one another, and offering helpful suggestions and solutions about what works best in the unit. There was a quote of the day and some planning about what would be happening in the morning, afternoon and evening, with the range of different clinical staff that all have input into the ward.

We spoke to staff throughout the two days, and we were able to see that the staff team knew the patients extremely well. There was a sense of commitment and experience in the staff group that was evident when speaking with the staff.

We reviewed the nursing care plans, and we found them to be varied in quality, most of the care plans were person-centred and where possible, reflected individual participation in their care. We noted that the care plans were reviewed regularly but were not meaningful and did not reflect changes in the individuals care journey.

On our last visit to the service, we made a recommendation regarding auditing of the care plans. On this visit we reviewed the audit tool that was being used. We found the audit focussed on quantitative information and lacked a qualitative approach. We also were shown another audit tool used in another part of the service, which had more of a qualitative focus. However, we were told that the staff had found this audit tool more challenging and time consuming to use.

Recommendation 1:
Managers should ensure that the audit tool that is being used has both a quantitative and qualitative component, to ensure that there is a consistent approach to care planning.

NHS Borders uses the electronic system, EMIS, for all patients' records. The ward staff had decided that due to difficulty in accessing care plans and involving individuals in their own care, they would print out the care plans and keep them in a folder. At the end of the episode of care these are uploaded to EMIS.

We noted in the chronological notes that the one-to-one discussions with individuals were evidenced throughout. The chronological notes for all patients gave a clear view of each patient's journey and were generally written to good standard.

During our meeting with the ward staff and the management team, we discussed ongoing concerns in relation to patients remaining in hospital when they are considered "fit for discharge". There was one individual who was considered a "delayed discharge". On discussion with the team, there appeared to be some confusion regarding the coding for the delayed discharge of this patient. The managers assured us that they would clarify this matter and update the Commission.

Multidisciplinary team (MDT)

We noted that the multidisciplinary team meetings (MDT) are held weekly with a range of professionals involved in the patients care. Patients are encouraged to attend those meetings.

We were pleased to hear that psychology has been added to the MDT, although at the time of the visit, only three hours per week was available to the service. While this was a positive step, it was difficult to envisage how this might be used effectively to improve an individual's care during their inpatient stay. We plan to ask the service for clarity around how this limited time will be used.

Use of mental health and incapacity legislation

On the day of our visit, three patients in the wards were 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 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 did have a concern about the use of intramuscular medication for one patient; we discussed this with the senior charge nurse at the end of the visit, and advised that a different approach with the timing and administration of medication may have been less invasive and more effective in the longer term.

When we were reviewing the records, we noted that one individual who was an informal patient was attempting to leave; the assessed level of risk was clearly noted in the individual's file. We discussed our concerns that there had been the possibility that the individual was in fact de-facto detained.

As the situation had changed by the time of our visit, we explained the importance of nursing staff being able to recognise when patients were not consenting to their admission and if necessary, to use their power to detain (s299 Mental Health (Scotland) Act 2015) pending medical review for assessment of the use of the Mental Health Act

Recommendation 2:
Managers should raise awareness of nursing and medical staff on the rights of individuals who may be detained without authority.

Rights and restrictions

On the day of our visit there was an individual requiring a higher level of staff support with continuous intervention. There was a lack of clarity around this, as the documentation in place did not clearly define who was responsible, noting one of the clinical team that was unlikely to be involved, whereas it should have been one of the nursing staff who had responsibility for this enhanced intervention.

Recommendation 3:
Managers should ensure that recording of continuous intervention is clear and authorised.

On our last visit to the service, we made a recommendation to ensure that restrictive practices were the "least restrictive". On reviewing of all individuals, we were able to see that this was

now implemented and there is now a "seclusion policy" should this requirement arise. On the day of this visit there were no individuals requiring this restriction.

When reviewing patients' files, we looked for copies of advanced statements. The term "advance statements" refers to written statements made under section 274 to 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. Advance statements are a way of ensuring that people with mental ill health are listened to and have their human rights respected. At the time of our visit, there were no individuals who had an advance statement. We would like to see evidence of attempts made to engage patients in discussion regarding advanced statements and the reason noted for any patient who does not have one.

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

We were impressed with the range, frequency, and commitment of staff to the activity and therapeutic engagement provided in Huntlyburn. As well as the morning community meeting that took place each day, called "positive steps", individuals could attend when they wished to. We were impressed with the enthusiasm of staff and the way in which individuals were able to lead on what was available to do that day.

Some of the activities available were massage and aromatherapy (weekly), a ward gym; we were told new equipment was on order. There was scheduled classes in Tai chi, mindfulness, and arts and crafts. Individuals also had access to an extensive garden area, with a greenhouse and raised beds, where vegetable and flowers are grown.

Individuals told us they found this morning group helpful and were appreciative of the support to ensure they were involved in this extensive and varied programme of activity.

Since our last visit, the service has employed an activity coordinator; it is anticipated that this role will continue to develop and enhance the patients' experience.

The physical environment

The ward has an open plan, seating/dining/kitchen area. All patients have access to a fridge and to help themselves to hot drinks. There is a large room used for visitors which has a pool table and a library.

The physical environment of the ward is of a good standard. The ward had been recently redecorated and painted, and the team have worked on making the ward more comfortable and pleasant for individuals. There was also new artwork on the wards which gives a less clinical feel to the environment.

Summary of recommendations

Recommendation 1:
Managers should ensure that the audit tool that is being used has both a quantitative and qualitative component, to ensure that there is a consistent approach to care planning.

Recommendations 2:
Managers should raise awareness of nursing and medical staff on the rights of individuals who may be detained without authority.

Recommendation 3:
Managers should ensure that recording of continuous intervention is clear and authorised.

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 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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