Mental Welfare Commission for Scotland

Report on announced visit to: Borders General Hospital, East Brig Ward, Tweed Road, Galashiels, TD1 3EB

Date of visit: 15 July 2024

Where we visited

East Brig is a 10-bedded unit that provides rehabilitation for individuals in the Scottish Borders. On the day of our visit, there were 10 people on the ward and no vacant beds.

We last visited this service in July 2022 on an unannounced visit and made recommendations on individuals' participation in their care and social work input to the ward. The response we received from the service was acceptable.

On the day of this visit, we wanted to follow up on the previous recommendations and look at and hear about any changes to the service, as a joint health and social care service had been opened to provide care for individuals who had previously been in East Brig and needed longer term care.

Who we met with

Prior to this visit we had a meeting with the consultant psychiatrist and the clinical nurse manager.

On the day, we met with and reviewed the care of six people, three who we met with in person and three who we reviewed the care records of. We also met with one relative. We spoke with the operational manager, the senior charge nurse, other nursing staff, the activities co-ordinator and domestic staff.

Commission visitors

Susan Tait, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

We spoke with individuals, and most were positive about the care they were receiving, saying, “staff are always around if you need them”, and “staff are great at helping you with your own interests”. However, one individual we spoke with did not share this view and felt that they were viewed negatively due to their diagnosis.

We discussed the issues they raised with staff on the day.

The enthusiasm and motivation of the care team was evident, staff talked about individuals with empathy and kindness. We attended the morning coffee group which took place each day to discuss what the plans were for that day. It was clear that individuals felt comfortable in the presence of staff and were able to air their views.

The ward continues to provide a welcome pack for new admissions to the ward. This not only gave a comprehensive overview of what they could expect during their stay in the ward, but also contained a small pack of essentials such as shower gel, toothbrush and toothpaste. This gesture, on admission, created a sense of being welcomed with dignity. We mentioned this in our last report and were pleased to note that this action had continued.

Care, treatment, support and participation

In the last report we made a recommendation about evidencing individuals’ participation in their care. During this visit we noted that this was still sporadic where ‘signing’ of care plans was asked for. However, signing a care plan is not always evidence of participation and we were able to review a new document that a student nurse had introduced and was trialling called doodle care plans.

This document enabled individuals to participate in short, ‘bite-sized pieces’ and it captured their views in a creative way. During discussions with staff, we were able to see that they were very supportive of the rehabilitation process for individuals and tried hard to engage with them with the aim of a successful discharge.

Care records

The system used by the service is EMIS and they had also introduced TRAKCare. The care plans were all in paper form for ease of accessibility for both staff and individuals and we were told that once the person was discharged, these were uploaded to EMIS. The information was reasonably easy to navigate.

The care plans we reviewed were of a mixed quality. Some were detailed and descriptive of the interventions required to support the person. Others were less detailed and often comprised of a list of things to do. The reviews of the plans were somewhat lacking in detail i.e. ‘no change’ over several months of reviews, without any details on how this might be addressed if the plan was not achieving its goal.

Recommendation 1:
Managers must review care planning to ensure care plans evidence participation, adequately describe the support and care which is being delivered and contain summative evaluations that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

We reviewed the risk assessments and again these were quite disparate. Some were current and had a risk management plan where risk was identified, and others had not been reviewed for some time. We did see an integrated care pathway which was very detailed, giving good historical information and planning for the future.

We looked at the day-to-day notes and whilst they were informative, some of the language used was not descriptive of the situation, for example, "evident around the ward".

We were told that there was an audit process, but it did not seem fit for purpose, as it did not reflect both qualitative and quantitative review of the care plans.

Recommendation 2:
Managers should review the current audit tool to ensure it adequately monitors the content and quality of the care plans.

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.

Multidisciplinary team (MDT)
In the last report we raised concerns about the lack of social work input. We were told that this had been resolved and there was social work input for all individuals.

The MDT comprised of nursing staff, a consultant psychiatrist, an activities co-ordinator, social work and mental health officers. A referral could be made to occupational therapy for assessment, physiotherapy, dietetics and speech and language therapy. Input from a pharmacy technician happened on a weekly basis at the MDT meeting. There were two junior doctors, who as well as being involved in mental health care, also provided physical health care.

One individual was receiving input from psychology, but this was on a 'one-off' basis. Psychology was not routinely available to individuals receiving care and treatment in East Brig, which left a significant gap in the care needs of the individuals receiving rehabilitative treatment.

[1] Person centred care plans: https://www.mwcscot.org.uk/node/1203

Recommendation 3:
Managers should review the psychology provision to East Brig to ensure that care provision matches individual need.

The MDT meeting took place weekly and was well attended by the professionals involved. There was a template used to record all relevant information about the individual's week, their mental state, and generally what had happened for them. There was a part where individuals could give their view, but this was rarely taken up by the individuals themselves. The service was looking to develop a more user-friendly document that would encourage participation and could be informed by the new 'doodle care plans'.

There was evidence of carer/relative input where there was contact. This was documented in the continuation notes and in the MDT meeting record.

There was a focus on discharge planning, although finding appropriate accommodation and the relevant support was challenging for the social work team.

Advocacy services were available for individuals from Borders Independent Advocacy Services (BIAS).

Use of mental health and incapacity legislation

On the day of the visit six people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

Eight individuals were being treated under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act).

All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment, were accessible.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and in all but one case, corresponded to the medication being prescribed.

We advised the SCN of the one T3 certificate and she said that it would be brought to the attention of the RMO as a matter of urgency.

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 that this was documented appropriately.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate under section 47 of 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. For the eight people who required a section 47 certificate, we found that four of them were not detailed enough to authorise the treatment prescribed. This too was brought to the attention of the SCN on the day, who said she would advise the RMO of this.

Recommendation 4:
Managers should ensure that 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 (third edition) and cover all relevant medical treatment the individual is receiving.

For individuals who had covert medication in place, all documentation was in order.

Rights and restrictions

East Brig had an open door during the day, which was locked at night for safety.

When we are reviewing patient files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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. In the notes we reviewed, we found one advance statement. There was information about advance statements in the welcome pack, which was provided on admission to the ward, and on notice boards.

The welcome pack also included the Commission's Rights in Mind[2] pathway.

Activity and occupation

The ward had 27.5 hours of activity co-ordinator provision per week. East Brig had exemplary input for meaningful occupation for individuals who were in a rehabilitation facility.

There was a morning coffee group each day to discuss the plans for that day and for future events. There were twice weekly meetings where individuals could ask any questions of staff about the ward or anything they felt important. Self-catering was in place for most people, with at least one meal a day being planned, shopped for and cooked. They had chickens which were cared for by individuals and staff. There were themed days and evenings which everybody could be involved in, if they wished.

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

There were visits to the local area, both unescorted and escorted by staff. There was a garden which was looked after by individuals and staff and provided a quiet space.

There was also a sound garden. There was forest bathing and although the weather had been inclement there were plans to reintroduce barefoot walking, both of which have an evidence base for positive mental health.

The ward had a car which provided individuals with links to the wider community. We were pleased to see the high level of active involvement that facilitated a positive rehabilitation experience for individuals.

The physical environment

The layout of the ward consisted of ten individual en-suite bedrooms. Everyone was encouraged to personalise their own space whilst they were there, and some had been involved in painting and decorating.

The ward was in an old building but used the space as best as it could. There was a separate dining room and sitting room, a pool/activities room and a space where individuals could meet with friends and relatives.

When the ward has reduced capacity in relation to the number of patients, one of the rooms was converted to a movie theatre, with particular attention being paid to having an authentic experience in a safe environment and the opportunity to practice social skills. It had snacks available and the opportunity to watch a film over a period of time, if individuals had trouble with concentration.

The ward was clean, fresh and well looked after. All spaces throughout had a comfortable atmosphere. There was lots of information available in public spaces that people could use, such as numbers for advocacy services, and the Commission’s telephone advice line.

Summary of recommendations

Recommendation 1:
Managers must review the care planning to ensure care plans evidence participation, adequately describe the support and care which is being delivered and contain summative evaluations that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 2:
Managers should review the current audit tool to ensure it adequately monitors the content and quality of the care plans.

Recommendation 3:
Managers should review the psychology provision to East Brig to ensure that care provision matches individual need.

Recommendation 4:
Managers should ensure that 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 (third edition) and cover all relevant medical treatment the individual is receiving.

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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