Mental Welfare Commission for Scotland

Report on announced visit to: The Ayr Clinic, Dalmellington Road, Ayr, KA6 6PT.

Date of visit: 23 October 2019

Where we visited

The Ayr Clinic is an independent hospital which offers low secure care for 36 men and women across three wards. The wards are: Arran Ward which has 12 female beds for assessment and treatment; Belleisle Ward which has 12 male beds for assessment and treatment; and Low Green which is a 12-bedded, mixed-gender ward which focuses on rehabilitation. All the wards provide en-suite accommodation for patients with a primary diagnosis of mental illness, personality disorder and/or learning disabilities.

We last visited this service on the 12 April 2018 and a subsequent follow up visit to Arran Ward on the 20 August 2018. On the initial visit we made recommendations regarding staffing levels, safety, evening activities, and the physical environment.

This visit was as part of our regular programme of visits to adult forensic services where patients are subject to restrictions on their liberty. We wanted to meet with patients and follow up on our previous visit recommendations and look at issues in relation to care and treatment including the use of legislation, rights and restrictions.

Who we met with

We met with and reviewed the care and treatment of 17 patients, and two relatives.

We spoke with staff within the wards throughout the day.

In addition, we met with the managers of the Ayr Clinic to discuss current issues and developments.

Commission visitors

Mary Leroy, Nursing Officer

Anne Buchanan, Nursing Officer

Lesley Paterson, Nursing Officer

Yvonne Bennett, Social Work Officer

Paul Noyes, Social Work Officer

Dr Mike Warwick, Medical Officer

What people told us and what we found

Generally, feedback from patients we spoke to in relation to their care and treatment was positive. Patients described staff as being supportive, approachable and respectful. We spoke with patients on all the three wards we visited.

Care, treatment, support and participation

We found care plans to be person-centred and individualised, and regularly reviewed and evaluated on all the wards. All patients in the Ayr Clinic continue to be managed using the Care Programme Approach (CPA) and this provides a robust framework for managing patient care particular in relation to the management of risk. Risk assessments on all the wards were robust and regularly reviewed.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

The Multidisciplinary team

As well as input from medical and nursing staff, we noted that patients on these wards had good involvement with the full range of multidisciplinary team (MDT) personnel, psychology, occupational therapy, and pharmacy. They could also access dietetics on a referral basis when required. We were told there has been a recent addition to the MDT; a social worker has now been employed to work specifically with patients in relation to improving links with local authorises including mental health officers, relatives and carers.

Trauma informed care approach

The staff on Arran Ward told us about their focus on "trauma informed care approach" and that they were working towards responding in ways that prevent further harm and support recovery, and address inequalities and improve life chances. We discussed some of the initiatives that are in place to assist with this process.

The service continues to have clinical psychology input, and this was commented on positively by both patients and family members we met with. Psychological formulations are undertaken with outcomes shared with the MDT. Psychological formulations are helpful for the patient and staff as they provide an understanding of presentation and behaviours. We were told staff have continued with a psychological informed approach to care with some having been trained in dialectic behaviour therapy (DBT). This approach emphasises a greater focus on emotional and social aspects of care, and helps the patient cope with extreme and harmful behaviours. Nursing staff are now regularly engaging in reflective practice sessions with input from psychology.

Nursing staff have received additional training to support patients who require a higher level of intervention. This training supports the view patients can learn new skills to help reduce stress, distress and conflict. With the recent introduction of the Safewards Model, patients

and staff told us the positive impact this model has had and we look forward to hearing about the further development of this initiative on the next visit to the service.

Patients' medication is formally reviewed on a weekly basis. The service also reviews medication pre-incident and post-incident, through changes in presentation and patient relapse. The pharmacist also conducts audits and review of prescriptions on a weekly basis.

There was also evidence of attention to physical health and access on a weekly basis to a general practitioner and a practice nurse with annual health checks and appropriate health screening. This is particularly important for some patients with a range of complex health conditions.

Use of mental health and incapacity legislation

The wards operate a locked door policy in response to the levels of restrictions the patients are subject to. All wards operate a locked door policy, this is in line with the level of security patients require in this setting.

We found the appropriate legal paperwork in place for the patients we reviewed and the patients we interviewed were clear about their legal status, as were the staff. Where required the required Section 47 certificates authorising medical treatment under the Adults with Incapacity (Scotland) Act 2000 were in place.

Patients had consent to treatment certificates (T2) and certificate authorising treatment (T3) forms where required, under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Rights and restrictions

The legal right to advocacy must include involvement of the advocate to support the person when important decisions about their care and treatment is being made. We discussed with managers the recent changes to the corporate contract to provide independent advocacy to patients within the clinic.

Given the level of restrictions patients within the service are subject to, we would expect there to be easy access to advocacy services for all patients. The recent change has resulted in a move from using local advocacy services to a service commissioned by the Priory and based in Glasgow. Ayr Clinic now has one advocacy worker attached to the service who provides 15 hours a week, of which seven hours are used for administration.

We felt that this compromised patients' access to this important rights-based service and would ask the service to monitor this closely and address any instances where patients were not provided with sufficient and timely advocacy support.

Recommendation 1:

Managers should ensure that access to independent advocacy is easily available and sufficient to meet the needs of the patients. This should include patient evaluation of this service.

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 saw good levels of activity both on and out with the wards. Generally, patients we spoke to seemed content with the activities available to them. Activities were very much based on personal choice and were recovery-focused.

On-ward recreational activities such as board games, arts and crafts and exercise activities were available. There was an emphasis on all the wards for community time out and, for patients with appropriate permissions, they were engaging in walking groups, swimming, leisure centre activities and outings to local cafes.

We also were informed of the plan by the lead occupational therapist to develop with the nursing team a programme of activities for the evening. We look forward to hearing about this development on our next visit to the service.

The physical environment

On our last visit to the service we had made a recommendation about the need for refurbishments of all the wards within the clinic**.** There has since been major improvements in the physical environment; new floor coverings, decor and soft furnishing have been upgraded.

Summary of recommendation.

1. Managers should ensure that access to independent advocacy is easily available and sufficient to meet the needs of the patients. This should include patient evaluation of this service.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

MIKE DIAMOND
Executive Director (Social Work)

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 MWC 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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