Mental Welfare Commission for Scotland

Report on announced visit to: Ward 9, Woodland View, Kilwinning Road, Irvine KA12 8SS.

Date of visit: 31 May 2021

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's Route Map (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out face-to-face.

Ward 9 is a 20-bedded adult acute mixed-sex ward in Woodland View in Irvine. We last visited this service on 9 July 2019, and made recommendations regarding the need for staff training for services that support individuals with a diagnosis of autism and complex needs.

We also wanted to hear from staff of their experience of caring for patients during the Covid-19 pandemic. This is because we were aware from local intelligence in-patient services saw a significant rise in mental illness acuity. Furthermore, with restrictions in place there was a reduced opportunity for patients to have input from allied health practitioners, therapeutic activity away from the ward environment and visits from friends and relatives.

Who we met with

We met with and reviewed the care and treatment of eight patients.

We spoke with charge nurse and other members of the clinical team.

In addition we met with the clinical nurse manager at the end of day meeting.

Commission visitors

Mary Leroy Nursing Officer

Yvonne Bennett Social Work Officer

What people told us and what we found?

Care, treatment, support and participation

On the day of our visit all beds were occupied with levels of bed occupancy having remained high over the past 12 months. Nursing staff told us there has been an increase in acuity, patients admitted from the community have been exceptionally unwell.

There is a view that social isolation, reduced service provision and anxiety in relation to the Covid-19 pandemic have attributed to an increase in mental health distress. There is a sense that patients' duration in hospital has been longer than in previous years.

We enquired about patients who were fit for discharge, but discharge was delayed. We were concerned to hear that half of the patients were recorded as having a delayed discharge. For some patients whose care we reviewed, they were awaiting new tenancies or for some packages of care. We were told this issue is being actively addressed through monthly monitoring meetings with both then local authority and inpatient service manager, and the local discharge co-ordinator.

Recommendation 1:

Managers should ensure that as well as regularly auditing the delayed discharge processes, that work continues alongside partners to expedite discharge.

Care planning and risk assessment

Patients generally reported good support from staff, and nurses were described as interactive and approachable. We reviewed all the individual patient files on the electronic system. The care plans were detailed and person-centred with good information about specific interventions to meet the identified needs. There was clear identification of needs agreed goals and interventions. There was some evidence of patient involvement in the care planning process. Examples of signing off and discussions that incorporated the patient's views. Also some comments of patients being unable to engage and comment on their care plans.

We noted that the Ayrshire Risk Assessment framework was well embedded in practice, dynamic, and shared across community and inpatient services. Those individualised plans were reviewed and regularly updated.

Nursing notes were of a high standard and there was evidence of close liaison with families. Full physical healthcare assessment was taking place on admission, and follow up and frequency of these were evidenced in the notes where necessary.

Multidisciplinary team (MDT) meetings

The documentation of the MDT meeting is detailed and provides a good record. The MDT meetings are held on a weekly basis. The clinical decisions that occur during those meetings are clearly documented and generate an action plan with outcomes and treatment goals.

Those weekly meetings were attended by medical and nursing staff, occupational therapist (OT) and when appropriate social workers. The MDT meetings also evidence patient involvement and attendance, some patients we met with spoke about their involvement in the and in the decision making process.

We discussed the 'the pan-Ayrshire Autism strategy' and the recently developed role of the Autism Spectrum Disorder co-ordinator, who works across the partnership. On our previous visit to the ward we asked about providing care and treatment for autistic people who access adult acute mental health services. We were pleased to see that the service has now introduced for all staff the NHS Education for Scotland's Autism Training framework. This training will ensure that the service can achieve key outcomes for people with ASD, their family and carers.

The staff commented that the staff team have built a level of enhanced skills and have an interest in eating disorders. The Community Eating Disorder Service is based in Irvine and the ward work closely together. This service has supported the ward with assessment, care planning, treatment and training specific to the needs of patients with an eating disorder.

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

Use of mental health and incapacity legislation

Copies of certificates authorising detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') were uploaded on to the electronic system. On the front page of the patient information sheet there was clear documentation of legal status with a link to the electronic copy of the document. We highlighted that it was important that the initial flagging system on care partner was an accurate reflection of the individual's legal status. We noted that one patient's legal status had been revoked and this was not accurately reflected on the care plan and the care partner alert system.

Within the ward most of the patients were subject to the Mental Health Act. Most treatment provided under Part 16 of the Act was authorised by either a T2/T3 certificate, however there were two omissions. These issues were highlighted to managers at the end of the visit.

Recommendation 2:

Managers should ensure consent to treatment documentation is audited to ensure that treatment is legally authorised.

Some of the patients in the ward were subject to guardianship under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). For one individual we did not find copies of relevant AWI Act guardianship order on file. It is important that staff know the specific powers that an

appointed guardian has under the AWI Act, and that copies of relevant guardianship orders are kept on file.

Recommendation 3:

Managers should ask guardians to provide a copy of any guardianship order granted and to make sure that this is filed appropriately.

Rights risks and restrictions

During the pandemic there has been an impact on visiting for relatives and patients, but visits are now resuming in line with government guidance. During lockdown the wards have used technology to ensure links with key people were maintained and these means of communicating have been a positive addition to the range of ways patients can maintain contact with important individuals in their lives.

On admission to the service the electronic system (care partner) prompts the nurse about whether the patient has an advance statement. Section 276c of the Mental Health Act states that support for advance statements should be published by NHS Boards.

There were details about how to access the advocacy service which was readily available and, where relevant, this was recorded in the patients' files, along with any legal representation that they had.

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

While we appreciate the pandemic has had an unwanted impact on the everyday schedule of therapeutic activities. The patients we met with were positive about the activities and groups on offer and able to discuss with us the activities they participated in and enjoyed.

The patients also have access to the Beehive activity hub. We were informed that during the pandemic patients did not have access to the service; however, through the remobilisation process, patients are able to engage with a variety of activities that are available. The service provides a good range of activities with some emphasis on encouraging people to be physically active.

The physical environment

The physical environment of the ward is of a high standard, it is modern, bright, clean and spacious. The ward has its own courtyard and garden which is landscaped with plants and shrubs, this outdoor space is appreciated and well used by patients on the ward.

Summary of recommendations

1. Managers should ensure that as well as regularly auditing the delayed discharge processes, that work continues alongside partners to expedite discharge.

2. Managers should ensure consent to treatment documentation is audited to ensure that treatment is legally authorised

3. Managers should ask guardians to provide a copy of any guardianship order granted and to make sure that this is filed appropriately.

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.

ALISON THOMSON
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 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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