Mental Welfare Commission for Scotland

Report on announced visit to: Ayrshire Central Hospital, Wards 3 & 4 Woodland View, Kilwinning Road, Irvine KA12 8SS

Date of visit: 3 February 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

We visited Wards 3 and 4 in Woodland View hospital in Irvine. Ward 3 is a 15-bedded mixed-sex ward which provides care and treatment for older adults who have a diagnosis of dementia. Ward 4 is also a 15 bed mixed sex ward who provide care and treatment for older adults who have a diagnosis of functional mental illness. On the day of our visit, Ward 3 had no vacant beds while Ward 4 had one vacancy. There were five patients from Ward 3 who were boarding in Ward 4 whilst awaiting suitable discharge arrangements.

We last visited Ward 3 in September 2019 and Ward 4 in February 2018 and made recommendations regarding access to Do not attempt cardiopulmonary resuscitation (DNACPR) and Mental Health (Care and Treatment) (Scotland) Act 2003 documentation, and joint work with health and social care partnership (HSCP) partners to expedite discharges.

On the day of this visit we wanted to follow up on the previous recommendations and also hear how patients and staff have managed throughout the current pandemic. As at the time of our last visit to the service we also wanted to find out if there had been progress made towards the recommendations made during the last visits.

Who we met with

We met with six patients within Ward 4 during our visit but were unable to meet with patients in the same way within Ward 3 to discuss their views due to the advanced nature of their diagnosis. In addition, we reviewed the records for a further six patients.

Due to Covid-19 imposed restrictions we did not have the opportunity to meet with family and/or carers as we normally would; we offered times for telephone consultation instead, however, we did not receive any requests for this involvement.

We had the opportunity to meet with a range of nursing staff across both wards as well as the relevant managers for the service.

Commission visitors

Yvonne Bennett. Social Work Officer

Mary Hattie, Nursing Officer

Mary Leroy, Nursing Officer

Justin McNicholl, Social Work Officer

What people told us and what we found

The patients we spoke to on the day were satisfied with the care and treatment they received within the service. There was a recognition of the impact of Covid-19 on how the service would normally operate, both in terms of the restriction on visiting arrangements and also on capacity within the ward to provide meaningful activity which, although understandable, was described as making it "a long day" for patients. This will be discussed this in more detail later in this report.

During the visit, we observed staff engaging positively with their patients and overall the ward was a calm and pleasant environment.

Care, treatment, support and participation

Within the electronic records of care we were able to access care plans and reviews which we found on the whole, to be person centred and timeously reviewed to reflect change. There was some discrepancy, however, in quality and consistency across the two wards which would benefit from an audit process.

We are aware that both Wards 3 and 4 have experienced some disruption resulting from Covid-19 outbreaks in terms of increased clinical demand and against a backdrop of reduced staff capacity due to staff sickness, isolation and a number of vacancies. An audit process will highlight areas for improvement as services move towards recovery.

Within Ward 3, we saw some instances of psychological intervention for a small number of individual patients and the benefit of this in formulating care plans, specifically for the management of stress and distress. We discussed with managers if there was an opportunity to further extend this intervention more routinely given the patient profile the ward serves. Managers agreed to investigate further to establish the potential for increasing this intervention.

Within Ward 3, we heard about the use of the 'Getting To Know Me' tool which involves patients where possible and their families in ascertaining the individual's person preferences, likes, dislikes and areas of interest or stress which support a person centred delivery of service. We did not, however, see evidence of this in practice or contained within care plans. This is an important tool for information gathering for people who are unable to communicate this information themselves; we would hope to see this further developed on our next visit.

We saw evidence of regular multidisciplinary team meetings (MDT) with the inclusion of relevant professionals as well as family and/or carers and advocacy, where they were involved. Where family and/or carers were unable to attend, there was good evidence of follow up by both junior doctors and nursing staff to ensure they were fully appraised of any decisions taken within this forum. Risk assessments were in place and reviewed routinely within MDT meetings.

Use of mental health and incapacity legislation

We reviewed the legal authority for ongoing care and treatment for patients within this service and found that all patients required statutory paperwork to be in place. We discussed the level of enhanced supervision for one patient who was not subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). We requested that this patient's

status is reviewed to ensure this sustained level of intervention is duly authorised and the patient's rights are upheld and subject to an appropriate level of scrutiny.

We looked at consent to treatment certificates (T2) and certificates authorising treatment (T3) for patients who were deemed unable to consent to treatment and found them to be current and relevant.

During the visit we heard that a number of patients were subject to "AWI". On further investigation, this referred to medical treatment for these patients being authorised by a certificate issued under section 47 of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') on the basis that they had been assessed as lacking capacity to consent to this treatment. This terminology can give rise to some confusion in relation to what legal authority is in place for an individual patient. Being subject to the AWI Act could mean that there is a power of attorney or that a welfare guardian has been appointed and we would urge services to be specific about what specific measures under the AWI Act are in place to ensure clarity around the existing legal authority for individual patients.

In October 2021, the Mental Welfare Commission published an advice note entitled *The scope and limitations of the use of section 47 of the Adults with Incapacity Act* – this is a useful practice guide which will support a more accurate use of terminology to avoid confusion.

A link to this document can be found at: https://www.mwcscot.org.uk/node/1638

Within the clinical records we saw examples of some confusion around the different legal powers authorised by the AWI Act and we discussed the need to revisit training in relation to Adults with Incapacity legislation for staff within the service. We are reassured that there are plans in place to address this potential knowledge gap. We look forward to seeing progress in relation to this activity on our next visit.

Recommendation 1:

Managers should audit the quality and consistency of care planning and reviews.

Recommendation 2:

Managers should ensure staff have access to training in Adults with Incapacity (Scotland) Act 2000 to ensure their practical understanding of this legislation.

Rights and restrictions

Both Wards 3 and 4 operate a locked door policy commensurate with the needs of the patients cared for within this environment. Where restrictions were in place, these were in the main authorised by appropriate legislation and were in line with risks identified within individual risk assessments.

We requested a review of one patient's legal status who had been subject to a sustained period of enhanced observation on an informal basis and we will follow this up with the service

One area of significant concern was the number of delayed discharges the wards were managing. On the day of the visit there were 13 patients who were deemed fit for discharge. For some of the patients, there were plans in place to move when the appropriate care arrangements became available but for others discharge plans were less clear. Some patients required legal authority to be in place before they could move from hospital and there were

significant delays in this being processed. We will address this separately with the relevant Health and Social Care Partnerships.

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/rights-mind

Activity and occupation

We heard from some patients that they did not have access to regular meaningful activity and as a result felt that it was "a long day" on the ward. We discussed this further with the staff and were advised that there are no ward-based activity coordinators and that this is by default the responsibility of the ward staff. This has been difficult to prioritise against a backdrop of increased clinical need and staff shortages as a result of Covid-19 absences and vacancies. Some groups have resumed and there are plans to resume more regular activities as services enter the recovery phase. We would urge managers to consider the value of having dedicated activity coordinators within these wards to ensure that meaningful activity can be delivered routinely. We look forward to seeing progress in this area on future visits.

The physical environment

Wards 3 and 4 in Woodland View offer bright, pleasant environments which have been made homely and comfortable. Patients are accommodated in large single room accommodation with en-suite bathing/toileting facilities. There is access to a number of small lounges and seating outwith the main lounge space to offer a lower stimulus area, if required. In addition there is access to an enclosed garden area which is in the process of being upgraded to maximise outside space when the weather allows.

Good practice

We heard during our visit of two development initiatives which have recently been tested within this service. The first related to an early discharge initiative where staff from the ward supported in a transitional phase from the ward until local services were in place, thereby reducing length of admission and providing support at a crucial point in transition. This has evaluated positively and the service are now in the process of considering how to resource this on an ongoing basis.

The second initiative relates to the piloting of additional support care home liaison nurses. Care home liaison services are well established within the area but these additional support nurses have the capacity to meet with the ward on a weekly basis to discuss the particular needs of patients who are transferring to care homes, offer additional information and support to potential placements and support the transition from the ward to the placement. Additionally the care home liaison nurses can provide support, advice and guidance to already established placements which may be at risk of breakdown to prevent admission and reduce disruption for the patient.

Summary of Recommendations

1. Managers should audit the quality and consistency of care planning and reviews.

2. Managers should ensure staff have access to training in Adults with Incapacity (Scotland) Act 2000 to ensure their practical understanding of this legislation.

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.

Suzanne McGuinness
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 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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