Mental Welfare Commission for Scotland

Report on announced visit to: Woodland View Hospital, Ward 7A, Kilwinning Road, Irvine, KA12 8RR.

Date of visit: 14 June 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.

Ward 7a is a mixed-sex, eight bedded unit that provides assessment and treatment for patients who have a learning disability, with significantly complex health care needs often associated with a diagnosis of autism spectrum disorder.

We last visited this service on 5 October 2020, and made no recommendations on the visit.

Who we met with

We interviewed four patients on the ward, and reviewed notes of all the patients interviewed. We met with three relatives.

We spoke with the senior charge nurse (SCN), and we met with members of the clinical team including the consultant psychiatrist, service manager, and nursing staff who were on duty on the day of our visit.

Commission visitors

Margo Fyfe, senior manager (practitioners), west team
Mary Leroy, nursing officer

Care treatment support and participation

The patients we spoke to were positive about the care given on the ward. Some were unable to give details on their stay due to the acuity of their symptoms and presentation, others were able to tell us about the routine on the ward, access to activities and the support that they had received from the clinical team.

The relatives we met with were complimentary about the staff in the clinical team. They were confident that their family members were receiving good care, and staff were friendly and approachable. The families told us they were consulted with by the staff team in relation to treatment decisions, and contacted if there were any concerns. We also saw evidence in the patient files of engagement with families, and families participating in decisions about care and treatment.

The ward is supporting a partnership approach to the provision of care and treatment, and the staff are encouraging relatives to be as involved as they want to be, in the provision of care and treatment.

A theme that did arise from meeting the families was a "concern about when the individual was fit for discharge", and questions about whether specialist services would be available in the community to support the complex care needs of their family members.

We also observed effective nursing leadership which has impacted on both the patient experience and outcomes, nursing staff and retention. We spoke to staff throughout the day 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 shone through when speaking with the staff.

The patients on the ward have their care and progress managed using positive behaviour support (PBS) plans and, for some, the care programme approach (CPA). On reviewing the individual's files we saw evidence of detailed assessment, supported by risk assessment and risk management plans. Risk management plans were reviewed regularly throughout the patient's journey.

We found nursing care plans to be person-centred and recovery focused, with clear specific interventions to meet the identified needs. However, we did not see enough information being consistently recorded in the review of the nursing care plans.

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/node/1203

Recommendation 1:

Managers should carry out an audit of the nursing care plan reviews to ensure that they fully reflect the patients' progress towards stated care goals, and that the recording of the reviews are consistent across all care plans.

Multidisciplinary team

The ward provides a multidisciplinary team approach to care and treatment. The multidisciplinary team (MDT) consists of nursing, psychiatry, psychology, and occupational therapy (OT). There is regular access to pharmacy, dietetics and other allied health professions on referral. Social work and advocacy are also accessible.

The MDT meeting records were well documented, recording who attended each meeting and contain a concise summary, with clearly recorded outcomes and actions.

We heard about the input from the wider psychology team whose input focused on cognitive assessment and facilitating complex case discussions. The nursing team discussed that the ward continued to benefit from input from the psychology assistant, who attends the wards two days a week. Their focus is on the review and implementation of the positive behaviour support plan (PBS).

We were told that the nursing team have two nurses who are trained in the PBS model (level four). We heard that the nursing staff are keen to develop their skills in the positive behaviour support model, to ensure patients are provided with care that offers safety and stabilisation.

We note that an OT has recently been employed and we were told about some plans regarding their role in the team to look at sensory/functional assessment and discharge planning, group work and individual sessions. We look forward to hearing how this progresses at future visits.

There were a number of patients who have been in hospital for a considerable length of time. For some the length of admission to hospital was due to the nature of their illness, and the complexity of their care needs, for others it is the challenge of finding suitable community placements to meet their complex needs.

During our pre-visit 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 are three patients who are currently considered 'delayed discharges' and this position remains a source of frustration for patients, relatives and the clinical team.

We recognise this is a nationwide concern, although the clinical team discussed ongoing issues with finding appropriate specialist services that the patients may require, challenges securing suitable tenancies and packages of care in the community to support the individual needs.

We appreciate that this is under regular review and we will be seeking updates from the management team in relation to progress, for those patients whose discharge is delayed. We will write to seek an update from local authority regarding this matter.

Recommendation 2:

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

Use of mental health and incapacity legislation

On the day of our visit, eight patients were detained under the Mental Health (Care & Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Mental Health Act paperwork pertaining to all detained patients which was easy to access, and was all in order.

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, and corresponded to the medication being prescribed. For people who unexpectedly need urgent medication, treatment given under s243 of the Mental Health Act and the Commission should be notified through the use of a T4 form. We found that most treatment provided under Part 16 of the Act was authorised by either a T2/T3 certificate. On review of the respective documentation, we noted that there was an omission regarding T4 documentation, these issues were highlighted to managers at the end day meeting. We will write to the respective responsible medical officer (RMO) seeking clarity, and an update regarding this matter.

Recommendation 3:

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

Where a patient is subject to the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act',) we were able to locate relevant paperwork including copies of welfare "proxies" guardianship orders.

Where a patient was assessed to lack capacity in decisions relating to medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. We were able to access all section 47 certificates and their accompanying treatment plans.

Rights and restrictions

On the day of our visit there were three patients requiring a higher level of staff support with continuous intervention. The clinical team reported that there were an increased number of patients being placed on continuous interventions. There is recognition from the senior leadership team that whilst continuous intervention to support patients during acute phases of distress and illness is at times necessary, it can be considered a restrictive practice.

In ward 7a there are a number of restrictive practices commensurate with the level of risk. There are requirements to ensure the safety to patients and staff is not compromised and procedures in place to reduce the potential risk to safety and security.

From reviewing of patients files we could see staff have built positive, recovery focused relationships with each patient while providing care that is both psychologically informed and offers emotional security

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

As with many of the services we have visited recently, the surge in clinical demand has resulted in a reduction in the service to offer an optimum level of meaningful activity in a busy ward.

In ward 7a, the nursing staff provide activities on a daily basis. A nurse is identified on each shift to arrange activities for the day. Due to the nature of the patient's needs most activities are on a one-to-one basis. We saw staff engaging in activities during our visit.

We also discussed that due to the pandemic there had been an absence of links with community activities, and this has had a significant impact on the patients care. The service is remobilising and re-engaging in community activities.

The patients told us that they met on a weekly basis, to identify activities they wish to participate in during the week. We also heard during interviews with the patients, that they enjoyed the opportunity to meet and plan the activities for the up-and-coming week. During our interviews with some patients, they told us about the range of activities available to them and what they had participated in.

The physical environment

Ward 7a in Woodland View offers a bright and pleasant environment that has been made homely and comfortable. Patients are accommodated in large single room accommodation with en-suite facilities. There is access to a number of small lounges. The courtyard garden is pleasant and well maintained and easily accessible for patients.

The clinical team did state that the space in the ward area was limited, and the environment could be challenging especially during periods of time when a patient may become stressed or distressed. The clinical team expressed that the ward is not bespoke or designed for the complex needs of the patient group.

They informed us of an attempt to access the ward space next door, but they had been unsuccessful with this request.

Any other comments

We were informed by senior manager of the ongoing review of staffing and the environment, focusing on staff numbers and high levels of violent and aggressive incidents.

On the day of our visit, the clinical team told us, that the ward were identified as a pilot team for the Scottish Patient Safety Programme (SPSP). This is part of a national collaborative to ensure "Everyone in adult mental health inpatient ward experiences high quality and person centred care every time".

For ward 7a, this improvement and training was focused on human rights and trauma informed care, and the reduction of restraint and seclusion.

The ward have identified a model for improvement that will focus on the impact of behaviours that challenge both patients and staff. The team have identified the “Beat It” model which is a structured programme for supporting individuals to engage and reflect on the benefits of activities, and assists the individual develop a greater understanding of the impact of being active on wellbeing.

This model is being trialled in various contexts across the Ayrshire Learning Disability services. In ward 7a, there are specific staff trained to facilitate implementation of this model. We look forward to hearing about the development of this initiative, and its impact on improving patient care, on our next visit to the service.

Staffing

We were told that the ward currently has no vacancies, but that one member of staff is going on maternity leave and one staff member is being redeployed.

The team also discussed the challenges recruiting staff in this present climate. The team are having to use bank staff due to the high levels of continuous intervention on the ward. The clinical team ensures that the bank staff have access to patient’s care plans and risk assessments, and have completed respective mandatory training, to ensure patient care and safety. However, due to the complexity of presentation for some patients, when being supported by a staff member who has less experience, this can impact on consistency of care. This matter is being carefully monitored and managed with in the service.

Summary of recommendations

1. Managers should carry out an audit of the nursing care plan reviews to ensure that they fully reflect the patients' progress towards stated care goals, and that the recording of the reviews are consistent across all care plans.

2. Managers should ensure that as well as regularly auditing delayed discharges processes. That work should continue alongside partners to expedite discharge.

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

Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving this report.

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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