Mental Welfare Commission for Scotland

Report on announced visit to:

Ailsa Hospital, Dunure Ward, Dalmellington Road, Ayr KA6 6AB

Date of visit: 29 August 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.

Dunure ward is a 14-bedded mixed-sex ward for adults, on the Ailsa Hospital campus in Ayr. The ward provides assessment and treatment for individuals over 65 years, who have complex care needs, functional psychiatric illness, and who may present with stressed and distressed behaviours. On the day of our visit all the beds were occupied.

We last visited this service on 19 October 2019, on this visit we made a recommendation related to the Adults with Incapacity (Scotland) Act 2000 (AWI Act). On the day of the visit we wanted to follow up on the previous recommendation, and also to have the opportunity to hear from patients, on their views on the service, and the care and treatment they receive.

Who we met with

We interviewed six patients on the ward, and reviewed notes of all the patients interviewed. We had a telephone contact with one relative.

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

Commission visitors

Mary Leroy, nursing officer
Douglas Seath, 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.

We spoke with one relative, who was complimentary about the staff in the clinical team, who was confident that their family member was receiving good care, and stated that staff were friendly and approachable. The relative told us they were consulted with, 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 when appropriate participating in decisions about care and treatment.

We observed excellent nursing leadership which has had a positively impact on patient experience and outcomes, nursing practice and staff retention. We spoke to staff throughout the day and we were able to see that the staff team knew the patients extremely well.

We reviewed the individuals' electronic files. We found that the care plans were person-centred and an accurate reflection of the care delivered, enabling the patient to achieve their goals. There was evidence of service user involvement, particularly for some patients where their care plans used language and descriptions that the patient was likely to have used to describe their own illness. There were detailed care plans for physical and mental health needs, and care plans for the management of stress and distress, incorporating information on triggers and management strategies.

Nursing care plan evaluations/reviews were regular. In the individual files we looked at, we saw that the reviews were thoughtful and meaningful, and detailed progress and changes in patient care.

We saw evidence of detailed risk assessment, supported by multidisciplinary risk assessment and risk management plans. Risk management plans were reviewed regularly throughout the patient's journey.

We enquired about patients who were fit for discharge, but where discharge was delayed. We heard of three patients that were recorded as having a delayed discharge. In reviewing these patients, we noted that services were seeking a package of care to support one individual in a community setting, and for the other two, the service was seeking a suitable residential placement. The multidisciplinary meetings and chronological notes provided details that this matter was being actively addressed, and that social workers were carrying out respective assessments.

Multidisciplinary team (MDT)

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

The MDT meeting records were well-documented, also noting who attended each meeting; they contained a concise summary, with clearly recorded outcomes and actions. We heard that the service is making a concerted effort, when possible, to involve families in the MDT meetings. Patients are offered the opportunity to attend this meeting; we were told that many chose not to attend. The team informed us that following the MDT meetings, either the medical or the nursing staff will update the patient, and when appropriate family, of the discussions and outcomes.

Use of mental health and incapacity legislation

On the day of our visit, six patients were detained under the Mental Health (Care & Treatment) (Scotland) Act 2003 (the Mental Health Act). We reviewed the legal authority for ongoing care and treatment for the patients in the ward and found all statutory paperwork in place.

Treatment provided under Part 16 of the Act was authorised by either a T2/T3 certificate. We reviewed 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.

A previous recommendation on our last visit related to the Adults with Incapacity (Scotland) Act, 2000 (AWI Act). When there is a guardianship order in place, or power of attorney (PoA), copies of the powers and contact details of the proxy decision maker are required to be on file. The service informed us of recent developments regarding this recommendation. We were pleased to note that all respective documentation was available on the patient's electronic file and we saw evidence of consultation with respective proxy decision makers, where appropriate.

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 no patients required higher levels of staffing support or continuous intervention.

The ward operates a locked door policy commensurate with the needs of the patients cared for in this environment. Where restrictions were in place, these were authorised by appropriate legislation and were in line with risks identified in individual risk assessments. We reviewed the locked door standard operating procedure. On the day of our visit we did note that the notification of the locked door policy was visible at the front entrance to the ward.

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 of the service to offer an optimum level of meaningful activity in a busy ward.

In Dunure ward the nursing staff provide activities on a daily basis; the activity programme is arranged by the nursing 'activity champions'; the choice of activities are patient-led, and are identified through an assessment of need. This also ensures that each patient has a personalised activity timetable.

We saw staff engaging in a light exercise group on the day of our visit.

We also discussed that due to the pandemic, there had been an absence of links with community activities. The service is remobilising and re-engaging in community and social activities.

During our individual interviews with patients, they told us about some recent activities they had participated in, describing walking and gardening groups and recent social trips.

The physical environment

The ward has been recently refurbished and is bright and airy, was well maintained and clean. This was also commented on, and appreciated by some patients when we met with them. The ward areas are maintained to a high standard, using soft lighting and artwork to personalise the space. The sitting areas were well furnished and comfortable. Patients' bedrooms were personalised with photos and belongings.

The garden area was easily accessible for patients via patio doors. It is enclosed area that was pleasant for patients to sit in, well stocked with plants, and well-maintained. We were told by the staff and patients that the garden space is well used, and enjoyed by all. We also heard from the clinical team that there is funding available to improve the slabbed/patio and path area.

Any other comments

We were informed of a recent educational development by the service. They have developed a LearnPro module that focuses on the Mental Health Act, as well as updating the existing AWI Act. Both modules are with the local training department, who are in the process of uploading on to the LearnPro platform. We look forward to hearing more about this development on our next visit to the service.

Summary of recommendations

No recommendations were made for this visit.

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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