Mental Welfare Commission for Scotland

Report on announced visit to:

Ayr Clinic (Arran & Low Green Wards) Dalmellington Road, Ayr KA6 6PT

Date of visit: 22 November 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.

The Ayr Clinic is an independent hospital that offers low secure care for 36 men and women across three wards. The wards are: Arran which has 12 female beds; Belleisle which has 12 male beds; and Low Green, a 12-bedded, previously mixed gender, ward – however, currently this ward is for males only. All wards care for patients with a primary diagnosis of mental illness, personality disorder and/or mild learning disabilities. All patients are subject to compulsory treatment provided under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedures (Scotland) Act 1995. On the day of our visit there were no vacant beds.

We last visited this service on 2 December 2021and we made no recommendations.

Unfortunately, prior to the visit, there was an outbreak of Covid-19 in one of the wards that had an impact on our visit. As a result of this, we were not able to visit Belleisle Ward as a number of patients and staff had tested positive.

On the day of this visit we wanted to look at care and treatment and ensure it was compliant with the legislation and patient's human rights.

Who we met with

We met with, and reviewed the care of 13 patients, all of whom we met with in person; we also reviewed their care notes and care planning documentation. We have had follow up contact from a relative, and a further two patients

We spoke with the hospital manager, the director of clinical services, charge nurses and the medical director.

Commission visitors

Mike Diamond, social work officer

Douglas Seath, nursing officer

Justin McNicholl, social work officer

Mary Leroy, nursing officer

Dr Daniel Wilkes, medical officer

What people told us and what we found

Care, treatment, support and participation

We met with 13 patients on the day and have had further information that we will raise with managers at the Clinic. There were a range of issues to take forward with the managers including standard operating procedures, use of the garden, window ventilation, food provision and dental treatment.

In general terms, the feedback from patients was positive in relation to the care & treatment they received from staff. We were told repeatedly by patients that they felt the wards lacked in staffing. We were informed by patients that the use of bank staff was very common. In discussion with managers we noted that there were vacancies for four qualified nursing staff, and eight healthcare assistants. This created a high demand on utilising bank staff to fill permanent vacancies. We feel that despite a recruitment planning and national shortages, managers should increase attempts to fill the vacant posts.

Staffing challenges were identified in the last report and some progress had been made in relation to occupational therapy and psychology, however, we felt there still remained a shortfall in trained nursing staff, and healthcare assistants.

Recommendation 1:
Managers should increase efforts to fill the identified nursing and healthcare assistant posts to offer patients better continuity of care.

We reviewed the care plans of patients; this informed us about care and treatment, and we found them to be recovery-focussed and person-centred. We noted patients were involved in the review process, in discussions and planning. Every patient's care plan is reviewed on a monthly basis and patients are encouraged to attend/discuss with their clinical team in advance. We saw evidence that Care Programme Approach (CPA) meetings are conducted every six months and are well recorded and attended; CPA is used in specialist mental health services to assess needs and then plan, implement and evaluate the care that patients require and we found that this provide care plans that were clear and well documented.

We noted the use of CALM cards in some files, which offer personalised de-escalation techniques which are applied prior to/avoiding the use of 'as required' medications (PRN). All patients who are prescribed and require to have high-dose monitoring, both have this in place and had all been recently reviewed.

Multidisciplinary team (MDT)

The Ayr Clinic has a range of disciplines either based there or accessible to them. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings, and update their involvement. This also includes the patient and their families, should they wish to attend. The allocated social workers from the originating area are invited to attend these meetings. Pharmacy are also involved at the Clinic once per week carrying out medication audits/reviews

During the pandemic meetings were conducted remotely via internet, but they are now trying to re-establish a face to face format.

Use of mental health and incapacity legislation

We reviewed the legal authority under the Mental Health (Care & Treatment) (Scotland) Act 2003 for ongoing care and treatment of patients in the Ayr Clinic and found all the required statutory paperwork to be in place.

We also reviewed the consent to treatment certificates (T2), and the certificates authorising treatment (T3) for all patients for whom this was required, and also found that all of the necessary paperwork was in place. This paperwork corresponded to the medication being prescribed. We found that all T3s had been completed by the responsible medical officer to record non-consent, and were available and up to date.

Where any patient lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found this was being appropriately managed.

Rights and restrictions

All of the patients in the Ayr Clinic are subject to compulsory treatment. Although the Ayr Clinic is a low secure hospital, most of the patients are subject to additional restrictions that are authorised under the Mental Health Act for specified persons. To do this, the responsible medical officer must formally notify the patient of their reasoned opinion for the necessity to implement these restrictions. We saw a range of evidence and could see on the management dashboard an efficient system of review and audit.

There is also an advanced statement drop in session every six months for patients to review their own statement and make any changes.

All patients were offered access to an independent advocacy service which was contracted to a local provider. This is mainly carried out by telephone contacts with patients. The contract will change in January 2023 when a different provider will take over. It is hoped that this will provide visits from advocates to the wards to engage with patients face to face. We heard from staff that they hope to set up a patient forum in the future

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-in-mind

Activity and occupation

The Ayr Clinic have a range of occupational therapy (OT) staff who work across the three wards at the Clinic and the two step-down wards. Ward planners were evident in the wards and the aim is offer 25 hours/week of meaningful activity to each patient. We were informed that all patients will have an interest check list that is personal to themselves.

However, we noted that the room that is used as a small gym was cluttered and unable to be used. The items require to be stored elsewhere, and the gym equipment must be in good working order.

Now that Covid-19 restrictions are lifting, and patients are once again able to resume community activities, they are having to again adapt and cope with the changes in routine this brings them. We heard that staff have gone the extra mile to facilitate activity and ensure patients' needs in this area are met. We were informed of various activities including board games, fishing, dog walking, volunteering placements, shopping, swimming, walking, and 10-pin bowling.

Recommendation 2:
The room used as a small gym should be de-cluttered and not used as a store. The equipment must be in good working order.

The physical environment

The Clinic is always utilised to maximum occupancy and therefore requires an ongoing programme of repair and redecoration. We were informed by some patients that the showers in Arran and Belleisle Wards only operate for a set time, and cannot be immediately switched on for a second period. This should be looked at by managers to see if improvements could be made to them.

Some patients found it frustrating that the bedroom windows could only be opened by a member of staff. This may be for security reasons, but where possible, patients should be enabled to open/close their own windows allowing fresh air or better air circulation.

In general, we felt that the fabric and décor were tired and in need of a more regular redecoration cycle. One patient told us they felt that some of the furniture was smelling.

Patients told us the tumble dryer had been broken for more than two months and needed to be replaced. This should be replaced immediately.

Recommendation 3:
Managers should review the redecoration schedule for the wards and expedite a more regular programme of refurbishment/redecoration. The tumble dryer should be repaired or replaced without delay.

Summary of recommendations

Recommendation 1:
Managers should increase efforts to fill the identified nursing and healthcare assistant posts to offer patients better continuity of care.

Recommendation 2:
The room used as a small gym should be de-cluttered and not used as a store. The equipment must be in good working order.

Recommendation 3:
Managers should review the redecoration schedule for the wards and expedite a more regular programme of refurbishment/redecoration. The tumble dryer should be repaired or replaced without delay.

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.

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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