Mental Welfare Commission for Scotland

Report on announced visit to: Ward 3, Woodland View Hospital, Kilwinning Road, Irvine, KA 12 8SS

Date of visit: 21 April 2023

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 Ward 3 in Woodland View hospital in Irvine. The ward is a 15-bedded, mixed-sex ward, that provided care and treatment for older adults who have a diagnosis of dementia. On the day of our visit, there were no vacant beds on the ward.

We last visited ward on the 3 February 2022, and made recommendations regarding care planning and access to training for the staff in Adults with Incapacity (Scotland) Act 2000. On the day of the visit, we wanted to follow up on the previous recommendations and hear from patients and carers/families.

Who we met with

We met with, and reviewed the care of seven patients, all of whom we met with in person; we also met with two relatives.

We had the opportunity to meet with a range of nursing staff, as well as the relevant managers on the day of the visit.

Commission visitors

Mary Leroy, nursing officer

Mary Hattie, nursing officer

What people told us and what we found

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 about their stay due to the acuity of their symptoms; 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.

Relatives we spoke with were complimentary about the staff team. They were positive in their views about the availability and quality of communication from both nursing and medical staff, and their experience of the care that their relative was receiving. They commented on the support provided, not just to the patient but also to them as families, in coping with a difficult diagnosis. For one relative they described the care and treatment in the ward as "outstanding". A number of relatives spoke about the welcoming and friendly atmosphere on the ward and told us "nothing was too much trouble to the staff".

We also observed strong nursing leadership that contributed to the patient's experience on the ward and positive outcomes in terms of care and treatment. 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 was evident through speaking with the staff.

On our last visit to the service, we made a recommendation regarding care planning. We heard from the service on a significant piece of work that they had been completed to improve the quality of care plans. This included specific care plan training for all registered nurses, and the training was based on the Mental Welfare Commission ("the Commission") good practice guidance on person centred care plans. The nursing team reported the benefits of the training, as it was delivered on a one-to-one basis. We found evidence of the impact of this initiative when we reviewed the electronic notes for patients.

When we reviewed the patients electronic notes, we were pleased to see initial assessments were detailed and we found completed and informative Getting to Know Me documents, (GTKM), What Matters to Me, and daily notes for each patient that we reviewed. These documents contained detailed information relevant to the individuals' comfort and care. Between them these documents, they provided information on an individual's background, their needs, likes and dislikes, and personal preferences that enabled staff to understand what was important to the individual and how best to provide person-centred care whilst the individual was in hospital. Risk assessments were reviewed at the multidisciplinary team (MDT) meeting and updated accordingly.

All the information gathered was used to compile care plans that are person-centred and had clear care goals. Care plans were reviewed on a regular basis and there were meaningful updates that charted the progress, or otherwise, towards care goals. There was evidence of patient and carer involvement in the care planning process.

Where individuals suffered from stress or distress, Newcastle formulations were in place. This is a framework and process, developed to help nursing and care staff understand and improve

their care for people who may present with behaviors that challenge. There were person-centred care plans outlining potential triggers and management strategies for the individuals.

Multidisciplinary team (MDT)
We saw in the electronic notes evidence of regular multidisciplinary team meetings (MDT) with inclusion of relevant professionals as well as family carers and advocacy.

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

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

We heard about the input from the wider psychology team, and current plans for the psychology services to review their input and analyse, with the local clinical team, what input from psychology services would be of most benefit to both the patients and the team.

We note that an occupational therapist (OT) was available on a referral basis only. Their role in the team was to offer support to both medical and nursing colleagues. We discussed on the day the value of OT input in providing a functional assessment and in supporting discharge planning and individual sessions. Given the complexity of the patient group, we felt there was a need to review the input from occupational therapy.

Recommendation 1:
Managers should review the level of occupational therapy input to ensure that this is adequate to meet the clinical needs and that it provides maximum patient benefit.

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 were considered fit for discharge. There were six patients who were considered delayed discharges. We discussed and reviewed some of those patients on the day of our visit.

The clinical team discussed ongoing issues with finding appropriate services/ placements. We recognise this is nationwide concern,

The service also highlighted the ways in which they are addressing this issue. All patients whose discharge was delayed were under regular review through multidisciplinary team meetings and weekly summary reports that were submitted to the head of service. There were also links with older adult discharge liaison groups, to review all delays for patients along with regular meetings with bed managers and social work representatives.

The pan-Ayrshire group meetings also reviewed in-patient pressures and barriers to discharge.

Use of mental health and incapacity legislation

During this visit, we discussed our previous recommendation regarding the training in Adults with Incapacity (Scotland) Act 2000. We heard that the service had developed a LearnPro

module to support staff in the application of this legislation, and shown the data on the nurses who had completed this training.

The service had also developed an electronic initial patient profile page. This created a flag on the system to ensure that staff could easily see when a legislative framework was is in place for an individual.

On the day of our visit, four patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). All documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act 2000 (AWI Act), including certificates around capacity to consent to treatment, were in place in electronic files and were up-to-date.

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. Certificates authorising treatment (T3s) under the Mental Health Act were in place where required, and corresponded to the medication that was prescribed.

In relation to the AWI Act, where the patient had granted a power of attorney (POA) or was subject to guardianship, we found information confirming this and contact details for the proxy decision maker were provided. Copies of the powers were available in all the files we reviewed and there was evidence throughout the chronological notes of consultation with proxy decision makers in relation to care and treatment.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI 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 completed forms and records of communication with families and proxy decision makers in all the files we reviewed.

Rights and restrictions

On the day of our visit, there were three patients that required a higher level of staff support with continuous intervention. There was 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.

The ward operated a locked door policy commensurate with the needs of patients cared for in this environment. Where restrictions were in place, these were authorised by appropriate legislation and in line with the risks identified in individual risk assessments

We heard that since the lifting of Covid-19 restrictions, visiting is now person-centred, which means there are no set visiting time. Due to the limitation and constraints of space in the ward, there was still a pre booking system in operation, to avoid the environment becoming too busy and overstimulating. Feedback from carers we met with on the day described an "open and flexible" approach to visiting.

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

In the ward, nursing staff provided the daily activities. Due to the nature of the patient's needs, most activities were 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 a reduction in links with community activities; this has had an impact on the patients care. At the time of our visit, the service was remobilising and re-engaging in community activities. We heard about the collaborative ventures with the local RAFA club (Royal Air Force Association) and Alzheimer Scotland, which provide support to local residents in Prestwick. The patients in the ward attend this local resource on a weekly basis, which helped to promote social inclusion, and kept connection with local events.

We discussed the ward's plan to purchase the Reminiscence/Rehabilitation & Interactive Therapy Activities (RITA), an all-in-one touch screen solution that offers digital reminiscence therapy. It is a relatively new tool in the fields of nursing and healthcare; it encompasses the use of user-friendly interactive screens and tablets to blend entertainment with therapy and to assist patients, particularly those with memory impairments, in recalling and sharing events from their past.

Their memories are accessed through listening to music, watching news reports of significant historical events, listening to wartime speeches, playing games and karaoke and watching films. We look forward on our next visit to see how this intervention is being developed in practice, and to hear about its impact on patient care.

We noted, and discussed, that historically there had been an identified nurse who had the role of ward-based activity coordinator. The ward no longer provides this dedicated role and patient activities were the responsibility of all ward staff. This situation was a challenging for staff to provide, as they have had to prioritise other roles due of clinical need.

We discussed the benefits and impact of a defined schedule of both recreational and therapeutic interventions that should be available to patients, and the potential positive clinical outcomes for patients, when staff and patient interaction is improved.

Recommendation 2:
Managers should consider creating a dedicated ward-based activity co-ordinator post to support the ongoing development of activity provision in the ward.

The physical environment

The physical environment of the ward was of a high standard. The entrance provided a warm and welcoming introduction to the ward; there were meeting rooms off of the foyer that meant that visiting professionals and families had access to these rooms. There was also a small visitor's room, and all were furnished in a homely and comfortable way.

The kitchen/dining area was spacious, light and clean. Patients' bedroom areas were large, single rooms with en-suite bathing/toileting facilities. There was also access to several small lounges, and seating areas out with the main lounge that offered a low stimulus area, if required.

There was a large enclosed garden/courtyard that provided an opportunity for activities in a calm, outside space for patients. We were informed by the ward that there were plans to further upgrade this space and we look forward to seeing this on our next visit.

Summary of recommendations

Recommendation 1:
Managers should review the level of occupational therapy input to ensure that this is adequate to meet the clinical needs and that it provides maximum patient benefit.

Recommendation 2:
Managers should consider creating a dedicated ward-based activity co-ordinator post to support the ongoing development of activity provision in the ward.

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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