Mental Welfare Commission for Scotland

Report on announced visit to: Ward 4 Woodland View, Ayrshire Central Hospital, Kilwinning Road, Irvine, KA12 8SS.

Date of visit: 4 May 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 that is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

We visited Ward 4 in Woodland View hospital in Irvine. The ward is a 15-bedded, mixed-sex ward, which provides care and treatment for older adults who have a diagnosis of functional mental illness. On the day of our visit, there were no bed vacancies on the ward.

We last visited Ward 4 in 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 this visit, we wanted to follow up on the previous recommendations and hear from patients and carers/families.

Who we met with

We reviewed the care of seven patients, all of whom we met with in person. We also met with three 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.

We also had written communication from both the discharge planning nurse and speech and language therapist. These communications were helpful in establishing the context in which the service operates.

Commission visitors

Mary Leroy, nursing officer

Douglas Seath, nursing officer

Susan Hynes, 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 on their stay due to the acuity of their symptoms; others were able to tell us about the routine on the ward. We did hear from some patients, who told us that there was "a lack of structured activities", that the days could feel long and this led to feelings of boredom. This issue has been raised further on in this report.

All of the relatives we spoke with were positive about their experience of care and treatment of their relative in Ward 4; they were complimentary about the staff team. One family member we spoke to raised concerns regarding their relative's care and treatment. This matter was discussed with the senior charge nurse, who is investigating the matter further.

Again, as with the patients we interviewed, the issue of "lack of structured activity" in the ward that was also raised by some of the relatives.

In common with other areas of the NHS across Scotland, there have been local staff changes with nursing staff retiring, or leaving their roles for new opportunities. Some members of the clinical team are new to the ward, and they are in the process of learning and growing into the service. At present, there are two nursing vacancies, and the ward has utilised bank staff to maintain staffing levels.

Care treatment support and participation

On our last visit to the service, we made a recommendation regarding care planning. We heard from the service about a significant piece of work that they had undertaken to improve the quality of care plans. This included specific care plan training for all registered nurses, with training based upon on the Mental Welfare Commission ("the Commission") good practice guidance on person-centred care plans. The nursing team report the benefits of the training, which has been delivered on a one-to-one basis. We found evidence of the impact of this initiative when we reviewed the electronic notes for patients. All of the nursing care plans we reviewed in were detailed and person-centred. Care plans were recovery-focussed, with clear specific interventions to meet identified needs, and reviews were thoughtful and meaningful, providing detailed progress and changes in patient care.

We were pleased to see that risk assessments had been reviewed at the multidisciplinary team (MDT) meeting and had been updated accordingly.

With an increase in referrals for patients who also had "complex physical health care needs", we saw defined physical health care plans, reviews and respective interventions to address the individual's needs.

There was some evidence of patient involvement in care plans, and where appropriate, involvement of family/carers too. In the electronic system, there was a section that provided evidence of patient involvement, and views of their care plans.

Multidisciplinary team (MDT)

In the electronic record, there was evidence of regular multidisciplinary team meetings (MDT). Ward 4 has a broad range of disciples 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 was invited to attend the meeting and update on their views. This also included the patient, and their families, should they wish to attend.

It was clear to see from the record where patients had made progress or whether there needed to be adaptations to care plans.

We heard that psychology input was highly valued by patients and there had been recent training for the staff team with a focus of psychology intervention related to trauma-informed care.

Nursing staff were also encouraged to attend training in relation to the "Newcastle Model". This is a model that is person-centred, has a bio-psychosocial approach that aims to support the clinical team and family members to manage ongoing stress and distress for the individual. Advanced training had been provided to embed the Newcastle model in the service.

We heard that an occupational therapist has sessional input into the ward. Their role in the team offered support to both medical and nursing colleagues. On the day of our visit, we discussed the value of OT input, in relation to functional assessment, discharge planning and individual one-to-one sessions.

Delayed discharges

On our last visit to the service, we raised concerns regarding the number of delayed discharges. We heard from the service that they have worked hard to address this, highlighting processes that have since been put in place to ameliorate this issue. While we were pleased to find that on this visit, there is a marked reduction in numbers of patients whose discharge from hospital was delayed, there were still three patients were considered to be delayed discharges. We discussed and reviewed those patients on the day of our visit, and heard from the clinical team about the ongoing issues with finding appropriate services/ placements.

All patients whose discharge was delayed were under regular review through the multidisciplinary team meetings, with weekly summary reports being submitted to head of service.

There were also links with older adult discharge liaison groups that reviewed all delays for patients, and there were regular meetings with bed managers and social work representatives.

In the service, we heard about the role of the discharge co-ordinator, who supports the patient's discharge from the ward; they adopt a lead role in discharge planning, supporting both the individual and the carer. This role involved assessment, support with symptom management, liaison with community services, support with medication management and relapse prevention planning. A pan-Ayrshire group meeting also reviewed in-patient pressures and barriers to discharge.

Use of mental health and incapacity legislation

We discussed our previous recommendation regarding the training in Adults with Incapacity (Scotland) Act 2000 (AWI). The service had developed an on-line teaching module to support staff in the application of this legislation, and we heard that all members of the staff team had completed this training.

The service had also developed an electronic initial patient profile page, as a method of highlighting on the system so that staff could quickly see any legislative frameworks that were in place for the 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 MHA and AWI, 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 (T3) under the Mental Health Act were in place where required, and corresponded to the medication that was prescribed.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is specified in relation to this and where restrictions are introduced it is important that the principles of the least restriction is applied. Where specified person restrictions were in place under the Mental Health Act we found reasoned opinions in place. Our specified persons good practice guidance is available on our website at: http://www.mwcscot.org.uk/512

For those patients under AWI, and a Power of Attorney (POA) or guardianship order was in place, we found information regarding this and the contact details for the proxy decision maker. Copies of the powers were available in the relevant files we viewed 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 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 completed s47 forms and a record of communication with families and proxy decision makers in all the files we viewed.

Rights and restrictions

On the day of our visit, there was one patient who required a higher level of staff support with continuous intervention. We were informed that for the patient who required this intervention, it was due to an increased falls risk.

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 was no set visiting time. Due to the limitations caused by constraints of space in the environment, the ward still operates a pre-booking system, to avoid the environment becoming too busy and overstimulated.

In discussion with families, we asked about the current visiting policy. For one family, we heard that this could be difficult regarding the timing of the visiting slot; for another family, they commented on restrictions with access to their relative's room.

At the end of day meeting with senior management, we discussed that the most recent advice from Scottish Government stipulated that current visiting times to hospitals are now open, and local services should ensure an open and flexible approach to visiting. It is vital that the local visiting policy meets the specific needs of all families and carers who wish to visit their relative.

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

We had heard from patients that they did not have access to regular meaningful activity and because of this, we heard that it was a "long day" on the ward.

Ward 4 has access to the Beehive, where there is a gym, and a pool table; the patients in the ward can access the service on Thursday and Saturdays for one hour on each day. The ward team have made enquiries regarding further availability.

We discussed the impact of Covid-19 pandemic, and how it had adversely impacted on the levels of activities in the ward, The SCN had described that historically there was a well-structured activity programme that had good links with the local community.

However, we were pleased to hear about the ward's plans to purchase a Reminiscence/Rehabilitation & Interactive Therapy Activities (RITA) system, which is 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 with memory impairments) in recalling and sharing events from their past. Those 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 to seeing how this intervention is being developed in practice, and to hearing about its impact on patient care.

We heard about this new initiative in the ward, which has been led by speech and language therapy.

It is a year-long funded project that will look at two areas: communication and dysphagia. The project outcomes include the development of a supportive communication environment, with the up-skilling of staff, to further improve in-patient mental health.

Future plans will have a weekly social communication group, and one-to-one interventions, which the speech and language therapist facilitates. When a patient moves to a nursing home, the outcomes from this project will support the preparation of the patient's life story and communication passport. We look forward to hearing about the development of this initiative and its impact on patient care on our next visit.

The service no longer has a ward-based activity coordinator; patient activities are currently the responsibility of the ward staff. This situation can be challenging for staff as they have to prioritise this against a backdrop of increased clinical need.

Recommendations 1:
Managers should consider creating a ward-based activity co-ordinator post to support the ongoing development of activity provision in this service.

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. Meeting rooms, which are off the main foyer, meant that visiting professional and families could meet in these rooms. There is also a small visitors' room. Homely furnishing enhanced the environment.

The kitchen/dining area was spacious, light and clean. Patients were accommodated in large single rooms with en-suite bathing/toileting facilities. There is also access to a number of small lounges, and seating areas out with the main lounge, offering a low stimulus area, if required.

There is a large enclosed garden/courtyard. The garden provided a calm outside space for patients to access. We were informed of the ward's plans to further upgrade this space and look forward to seeing the changes when we next visit.

Any other comments

There has been a recent increase in the presentation of complex physical health care needs for patients who have been admitted to the service. The team described good links with the main hospital, providing opportunities of shared learning, and they also receive support from the local advanced nurse practitioner (ANP).

The clinical team have highlighted the need for further training in some physical nursing interventions such as nasogastric feeding, catheter care and palliative care. The ward has continued to ensure there is the opportunity for further training and support to upskill the clinical team members to meet the changing needs of some of the patients who have been admitted to the ward.

Summary of recommendations

Recommendations 1:
Managers should consider creating a ward-based activity co-ordinator post to support the ongoing development of activity provision in this service

Service response to recommendations

The Commission requires a response to this recommendation 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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