Mental Welfare Commission for Scotland

Report on announced visit to:

Priory Ayr Clinic, Bellisle Ward, Dalmellington Road, Ayr, KA6 6PT

Date of visit: 9 August 2023

Where we visited

The Priory Ayr Clinic is an independent hospital that offers low secure care for 36 men and women across three wards. Bellisle Ward is a 12-bedded ward that provides care and treatment for men with a primary diagnosis of mental illness, personality disorder and/or mild learning disabilities.

We last visited this service on 2 December 2021 and made no recommendations. We had not visited Bellisle Ward since December 2021 due to Covid-19 restrictions, so for this visit, we wanted to meet with individuals and hear about their care and treatment during the Covid-19 pandemic and now that restrictions are beginning to reduce.

Who we met with

We met with, and reviewed the care of seven patients, five we met with in person and two who we reviewed the care notes only. We also met with one relative.

We spoke with the ward manager, service manager, hospital director, and psychology trainee.

In addition, we met with the manager and an advocacy worker from Circles Advocacy, who provided advocacy services for Bellisle Ward.

Commission visitors

Margo Fyfe, senior manager

Gemma McGuire, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Feedback from the individuals that we spoke with was generally positive. They spoke highly of the care they received from nursing staff and the responsiveness of staff across the ward. However, they highlighted frustrations at the limitations placed on them and at the process involved in being granted time off the ward. A number of people we spoke with felt that staffing numbers were low and that there was a reliance on bank and agency staff, which they felt could lead to a lack of consistency and delays in their care.

Throughout the visit, we saw kind and caring interactions between staff and individuals. Staff we spoke with knew the people in their care well.

Staffing challenges were acknowledged by managers who were hopeful that the situation would be helped by recent recruitment into nursing posts. The service uses bank and agency staff to ensure safe staffing and attempts to mitigate the effect of this by providing training to these staff in various aspects of care in the ward.

We heard there had been concerns about accessing speech & language therapy and physiotherapy services, but these had been addressed and these services were available when required.

Care, treatment, support, and participation

When we last visited the service, we found examples of person-centred, recovery-focussed care plans that showed each individuals' involvement in the discussions and planning of their care. On this occasion, we found care plans were divided into four specific areas – keeping healthy, keeping connected, keeping safe and keeping well. Care plans we reviewed showed individuals' involvement and used a person-centred approach, but were not detailed, nor did they address specific needs under these headings. We were unable to locate reviews that highlighted where there was targeted nursing intervention and individuals' progress. We discussed this with the ward manager, and while there was a clear awareness of reviews happening this not reflected in the paperwork due to difficulties with the electronic note system. We recommend that care plan reviews were carried out to ensure that they reflected the specific issues identified, that there was a record of work being done with individuals in meeting their care goals, and that the reviews were consistent across all care plans. There was evidence of regular one-to-one meetings between named nurses and individuals, and these were audited to ensure they are being offered.

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 they fully reflect individuals' needs and progress towards specific care goals, and that recording of reviews are consistent across all care plans.

We were pleased to see risk assessments were in place for all of the individuals we reviewed. There was detailed information about identified mental health risks and management plans. In the notes we reviewed, the physical health risks had been identified but were, at times, highlighted in the risk plan. They did not benefit from the same detail as the other risk documents and were lacking management plans in some cases.

Information on individuals' care and treatment was held on the electronic record system Care Notes. We found the information held in the daily care records that we reviewed was variable in quality. Some care records provided detailed and personalised information that included how the patient presented throughout the day, what they had accomplished, and aspects of the day that had been difficult. Other care records did not record this level of personalised information and used language such as, "visible on the ward" and "keeping a low profile", making it difficult to determine current issues or interventions. We would have expected to see a consistent standard of record keeping that was person-centred with detailed personalised information. Some of the notes that we reviewed lacked consistent recording of individual's mental state, where there was progress towards goals, and they did not reflect interventions recorded in their care plans. In discussion with managers, we heard that there were considerations for a consistent recording template for notes to be used.

Recommendation 2:
Managers should ensure that care records are personalised, goal and outcome focussed, and provide more detail regarding how individuals present throughout the day.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to the team. The MDT consisted of nursing staff, psychiatrists, occupational therapy staff, dietetic staff, and psychology staff. Referrals could be made to other services as and when required.

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and provide an update on their views. There was also a section in the meeting to offer the individual and their families an opportunity to add their views and ask any questions. Consultant medical staff were available on the ward twice a week to review and address any queries out with the ward meeting. The Care Programme Approach (CPA) was used with all individuals on the ward and comprehensive plans were recorded from these. There was evidence of community team, community social work, advocacy, and named person/next of kin involvement in these meetings where appropriate. In some notes we reviewed, discharge plans were not as detailed as we would have expected. The hospital social work role was vacant which has created a gap in care provision.

There continued to be involvement of psychology in supporting the care and treatment of all patients. The psychologist supported the development of a risk management plan through both individual and group work, which focused on psychological wellbeing, distress tolerance and aspects of recovery. We heard from an individual how beneficial he found this work to be.

Use of mental health and incapacity legislation

On the day of our visit, all patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) or the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act). The individuals we met with during our visit had a good understanding of their detained status, of their right of appeal, and how to access advocacy and legal advice. We were pleased to hear advocacy workers were regular visitors to the ward and have a contract with the Priory Group. We heard from individuals how advocacy helped support them to attend tribunals and with other aspects of their care. The current advocacy providers had been in place since February 2023 and considered that the service has become embedded in the ward, with an increased awareness of what is available. There were hopes to develop regular group sessions at Bellisle Ward, which we look forward to hearing about at our next visit.

All documentation relating to the Mental Health Act, Criminal Procedure Act, and Adults with Incapacity (Scotland) 2000 Act (AWI Act), including certificates around capacity to consent to treatment, were in place and had detailed care plans attached.

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. One s47 certificate was out of date, and we brought this to the attention of staff on the day of the visit.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, 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 that was prescribed. We found that all T2s and T3s had been completed by the responsible medical officer, were in order and up to date.

Any individual who receives treatment under the Mental Health Act or the Criminal Procedure Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this in the individual's file.

Rights and restrictions

Bellisle Ward operates a locked door, commensurate with the level of risk identified in the patient group.

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 an individual is a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied. On Bellisle Ward there were 12 specified persons. Where specified person restrictions under the Mental Health Act were in place, the documentation was in order with the reasoned opinion being evident. We did note that individuals, although having free access to the ward telephone, were restricted to having mobile devices for one hour per day, with devices being

held by staff at all other times. This was to manage safety and security concerns regarding internet and camera use, and as such, this should have been included in the safety and security specification along with a reasoned opinion for each person this applied to.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

Recommendation 3:
Medical staff should review current restrictions in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

When we reviewed patient files, we looked for copies of advance statements. The term advance statement refers to written statements made under ss274 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We were pleased to find 11 patients had advance statements in their notes (one had declined to complete one). On reviewing these, we saw that the quality varied, some being very detailed and others focussing more on environmental issues rather than treatment. We advised staff on the day to review the content of the advance statements with patients.

Our advanced statement good practice guidance is available at:

https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidancesep2018revision.pdf

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 were told during our last visit how the pandemic had an unwanted impact on the daily schedule of therapeutic activities based in and around the hospital site. Staff had worked hard to ensure individuals had access to as many activities as possible and individuals had let us know how important this was for their recovery. We were pleased to hear how the activity programme had expanded, with links to community groups and vocational opportunities that have since been re-established and further developed. Individuals told us that they valued the activities offered by the ward, feeling that it gave them a sense of purpose and value. Work opportunities were offered by a dog walking service and car valeting company, and there are opportunities for paid employment in the hospital shop and grounds. The occupational therapist and nursing staff also supported regular groups that included cycling, fast and slow walking, and swimming.

We saw that each individual had an activity plan that was personalised to their needs, and that they were involved in creating. One individual we spoke with reported that access to activities was dependent on engagement with occupational therapy, which they felt was unfair. They also reported limited activity opportunities if there was agreed time out. On reviewing the notes, we found that there was a full activity programme available but the ward manager

explained that activities for this person were out with the ward, where they would be accompanied by staff.

The physical environment

The layout of the ward consisted of 12 single rooms; all were en-suite. There was a lounge area and a separate dining area. Bedrooms were spacious and had storage and a safe for individuals to use. One bedroom we saw had flood damage to the ceiling. When we discussed this with the service manager, they were aware of this and had escalated this to the estates team. We were told that there were regular monthly walk rounds with managers and estate staff to ensure that any outstanding repairs were quickly identified and remedied.

The environment was clean, and we were able to see where efforts had been made to soften the public rooms. There was a games room and gym area in the ward; staff told us this was a popular area in the evenings and was well used. There was also a laundry and therapy kitchen which allowed individuals to develop and maintain skills in cooking and laundry. There was a quiet area and music room that could be used for visits, as well as a larger meeting room that was situated off the ward and used for visits involving children. The decor was tired looking in places, but we were told a refurbishment programme is underway and that the ward had recently received new sofas and chairs.

There was a small garden area which was accessible from the dining area, however access to this was limited and dependent on adequate staffing. We thought more use could have been made of this space, particularly for those individuals with no time out with the ward area.

Any other comments

We heard about new rules that will prevent smoking in the hospital estate, which were due to start in August 2023. Staff, individuals, and relatives, all expressed concern about the impact this may have. We were pleased to hear how staff had been proactive in discussing this with individuals who would be affected by this change, and have made suggestions for nicotine replacement therapy and other strategies that may be helpful. We suggested to the ward manager that these interventions should be documented more clearly in a care plan to enable the correct support to be in place and mitigate some of the anxieties expressed.

Summary of recommendations

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

Recommendation 2:
Managers should ensure that care records are personalised, goal and outcome focussed, and provide more detail regarding how individuals present throughout the day.

Recommendation 3:
Medical staff should review current restrictions in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk