Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 6, Woodland View Hospital, Kilwinning Road, Irvine, KA12 8SS

Date of visit: 10 October 2023

Where we visited

Ward 6 is an eight-bedded ward providing assessment and treatment for men who require low secure care and have a primary diagnosis of mental illness, personality disorder and/or mild learning disabilities.

All individuals 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 two vacant beds. There were two men on the waiting list, one was due to be transferred to Ward 6 imminently and one who required assessment from their own health board area prior to transfer. The ward accepts referrals from other health boards in Scotland and when we visited, there were four men who were placed out of their own health board area.

This was our first visit to the service.

Who we met with

We reviewed the care of six patients, three of whom we met with in person and three of whom we reviewed the care notes of only.

We spoke with the service manager, the senior charge nurse (SCN), the consultant psychiatrist, the charge nurse, a social worker, a staff nurse, a clinical support worker, and the pharmacist.

Commission visitors

Anne Craig, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

All the people we met with spoke highly of the team in Ward 6, stating that they were ''friendly, approachable and fair''. They particularly appreciated the time staff would spend with them. They told us they felt fully involved in their care decisions, even when they did not agree with the outcomes. We heard of some frustrations, due to limitations in the ward, particularly around restricted items and access to social media. There is a current programme of work exploring safe use of social media in the ward that patients reported as beneficial. They were pleased they are now allowed smart phones and internet access when in community settings.

Individuals in the ward said they were confident that if they had any issues or complaints, these would be dealt with promptly but everyone we spoke to felt there were no issues with their current care and treatment, telling us that all staff treated them with respect. Everyone we spoke to reported that Ward 6 was a safe, welcoming environment, and we heard from one person that it was the ''best care I've received in hospital''.

There was positive feedback about the quality of the food in the ward, although we did hear that mealtimes were very early, with lunch being 11:30am and dinner being served at 4:30pm. When we raised this with hospital managers, we were informed this had been looked at previously to try and adjust mealtimes, but due to portering and kitchen staff shifts this had not been able to be changed. They will review this again to see if mealtimes can be adjusted.

Nursing staff told us there had been a high turnover of staff in the last few years but that the staffing situation was more stable now. They described being supported and encouraged in their work, with a good training and development programme. They were pleased that there was now a permanent senior charge nurse in post and felt that this was beneficial for the nursing team; we heard that the leadership was bringing positive benefits for the care they could deliver. We were pleased to hear that two support workers in the ward were being supported to train as registered nurses through the Open University while still being employed by NHS Ayrshire & Arran. The 'earn while you learn' model for the development and training that helps to build the registered nurse workforce is a welcome development. One member of staff we spoke to hopes he will be able to be employed as a registered nurse in the ward once his training is complete.

We reviewed the care plans and found them to be person-centred and reflective of the needs of the individuals. We heard that the care plans were developed with each person, although due to the electronic patient record system used, Care Partner, a new care plan is created each time staff review the existing care plan; this can make assessing the success of the interventions and reviewing the progress towards the initial goal difficult. We heard there is work on care planning being undertaken, with learning from another ward in the hospital who had addressed this issue being considered. When reviewing the daily notes, it was difficult to link the interventions recorded with the person's current care plans. We would hope that the ongoing care plan review addresses how notes, care plan goals, interventions and outcomes are considered and recorded in individuals' daily notes.

Recommendation 1:
Managers should ensure nursing care plans fully reflect patients' progress towards stated care goals, and that the recording of the reviews are consistent across all care plans.

We found regular one-to-one discussions with nursing staff in individuals' notes. These included detailed information about the person's mental state, progress, and their hopes regarding ongoing treatment.

We saw that physical health care needs were being addressed in care plans and that recognition and treatment of physical health needs were well documented. We heard from nursing staff about a group that was run in the ward, focussing on men's physical health care. The group discusses various aspects of health and promotes the benefits of health screening and supports the men participate.

Multidisciplinary team (MDT)

The ward had a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, a forensic social worker, psychology, speech and language therapy and dietetics; there was also access to physiotherapy 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. The patient was always invited to attend, and if they decided not to, the consultant psychiatrist met with them individually, to ensure their views were reflected in the meeting. Patient involvement in these meetings was reflected in the minutes and these were recorded promptly and accurately, ensuring that all staff were able to be kept up-to-date with ongoing plans.

We were unable to find clear discharge planning information in the MDT meeting notes and spoke with staff on the day about ensuring this is added to all versions of the meeting note.

Care records

Electronic patient records were well organised, and it was easy to locate most of the information we were looking for. There was a holistic mental health assessment in each individual file. This gave an overview of the patient in terms of personal background, support network, the presenting complaint and mental health assessment, the mental health treatment history and patient's physical and functional status.

We saw that risk assessments were completed appropriately, and the paperwork appeared thorough and detailed, highlighting relevant risk areas. We were also pleased to see evidence of robust regular reviews of the risk assessments.

Care Programme Approach (CPA) documentation we reviewed was detailed with evidence of regular reviews. The CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment. Input from a range of allied health professionals was evident and it was clear from discussions that patients were fully aware of the content of reports prepared for their CPA meetings. There was evidence of patient and carer involvement in these meetings, with emphasis put on enablement and recovery and the involvement of the local outpatient care team. The ward's forensic social worker attended all CPA meetings and links with the patient's own social

worker to ensure ongoing consideration and understanding of forensic mental health needs and ensures consideration is given to future placement.

Use of mental health and incapacity legislation

On the day of our visit, all of the patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act). The patients we met with during our visit had a good understanding of their detained status, their rights of appeal and their right to access legal representation.

All documentation relating to the Mental Health Act or Criminal Procedure Act, including certificates around capacity to consent to treatment, were in place and 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. 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 being prescribed.

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

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 (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 one person who was deemed as lacking capacity and who required a section 47 certificate; this was in place but was out of date and had not been discussed with the person's Power of Attorney (POA). This was raised with staff on the day who agreed to address this promptly.

Where patients had a POA or guardianship order in place under the AWI Act, we would expect to see a copy of the certificate in the individual's file. We were unable to find a copy of the POA certificate in one case. Staff explained the copy they had been given by the attorney was illegible and they have requested a clearer copy; this will be followed up as a matter of urgency by the ward social worker.

Rights and restrictions

Ward 6 operates a locked door, commensurate with the level of risk identified with the patient group.

We heard about ongoing work in Ward 6 to review the level of restrictions in place and the proportionality of these. This has led to increased access to social media, opening up of the ward area at all mealtimes (bedroom access was previously limited at main mealtimes) and improved access to the therapy kitchen. It is recognised by the ward team that this has been beneficial to the patient group, who spoke positively about the changes.

Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place. 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 a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Six patients in Ward 6 were specified for safety and security, where specified person restrictions under the Mental Health Act were in place the documentation was in order.

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

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. Three patients on ward 6 had an advance statement, although it was unclear from reviewing the notes if the other three patients had been offered the opportunity to write one. We heard from hospital managers that there is ingoing work to incorporate this information into the electronic note system and this will be introduced in the next few months.

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 heard how the pandemic had had an unwanted impact on the everyday 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 patients let us know how important this was for their recovery.

We were pleased to hear that the activity programme has expanded and the recruitment of an occupational therapist six months ago had supported this. We were told by individuals they value the activities offered by the ward feeling it gave them a sense of purpose and value. The Beehive Centre in Woodland View offers regular activity sessions and groups for some of the men from Ward 6, and there is a weekly meeting between nursing staff and patients to agree the ward-based activity timetable for the coming week. There are regular groups offered in the ward including a newspaper group, anxiety management, fake-away cooking, and walking. There is a low intensity psychological therapy group, a therapeutic group exploring mental health, recovery, and substance misuse over a 28-week period. This is offered to patients from Ward 6, Ward 7c and those engaged with the community forensic mental health team. Feedback from patients was very positive and there was recognition of the benefits of meeting with people from other services.

The physical environment

The layout of the ward consisted of eight single en-suite rooms. There was a lounge area and dining area for the patients that were bright and spacious. There were two separate smaller lounge areas that could be used if people want a quieter space or to make phone calls. There was a fairly well-equipped gym area accessible from the main lounge area, and laundry room that has timetabled access. The environment was immaculate, and we were able to see where efforts have been made to soften the public rooms. There were two rooms that could each be locked off if there was a need for seclusion. This then provided a bedroom, separate living room and a separate area for staff to sit, as well as access to the outdoor garden area. Staff reported this was rarely used but there was a seclusion policy in place if it was required.

There were two large outdoor areas, accessible to the ward. One was a sports area and the other a garden area. These were currently being upgraded but seemed to be well used.

Any other comments

We were impressed on the day of our visit by the enthusiasm and commitment shown by staff in the ward. Everyone we met with commented on the positive changes in the ward over the last eight months and the progress towards a less restrictive environment. There was an acknowledgement by the senior team that the continued absence of a senior charge nurse had had an impact on the functioning and leadership in the ward, with a high level of turnover in staffing. We were pleased to hear the ward was now almost at full staff compliment and that a senior charge nurse was now providing leadership in the nursing team.

During our visit we heard about plans to develop a defined, staged planner and pathway for patients' journeys through the service. We also heard about the ongoing work to review the restrictions in the ward and look forward to hearing more about these when we next visit.

Summary of recommendations

Recommendation 1:
Managers should ensure nursing care plans fully reflect the patients' progress towards stated care goals, and that the recording of the reviews are consistent across all care plans.

Service response to recommendations

The Commission requires a response to this recommendation 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