Mental Welfare Commission for Scotland

Report on announced visit to:

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

Date of visit: 10 July 2024

Where we visited

Ward 6 is an eight-bedded unit situated in the purpose-built Woodland View psychiatric hospital in Irvine, North Ayrshire. The unit provides psychiatric assessment and treatment in low secure conditions for men suffering, primarily, from mental illness, learning disability and personality disorder.

On the day of our visit, there were six people receiving treatment on the ward, with two vacant beds. All individuals were subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedures (Scotland) Act, 1995 (Criminal Procedure Act). The ward accepts referrals from other health boards in Scotland and when we visited, there were two men who were placed out with their own health board area.

We last visited this service in October 2023 on an announced visit and made recommendations on ensuring nursing care plans fully reflected the patients' progress towards their stated care goals, and that the recording of the reviews were consistent across all care plans.

On the day of this visit, we wanted to follow up on the previous recommendations and hear how the service had addressed these. We heard that care planning was part of a care assurance audit program and that that this has also been included in clinical supervision discussions with registered mental health nurses (RMN) staff.

Who we met with

We met with, and reviewed the care of six people, five of whom we met with in person and one who we reviewed the care notes. While there were no relatives/carers or advocates available on the day for us to speak with, we could see evidence of Commission posters on the walls, and the SCN had offered visitors the opportunity to speak with us prior to the visit.

While visiting the ward, we had the opportunity to speak with a member of nursing staff and had email contact with the occupational therapist (OT) after the visit.

During the end of day feedback, we spoke with the general manager, the senior charge nurse (SCN), and the consultant psychiatrist who is currently covering the ward.

Commission visitors

Paul Macquire, nursing officer

Mary Leroy, nursing officer

What people told us and what we found

The individuals we spoke with on the ward were very complimentary about the staff and the ward. One individual said “the staff are very helpful and kind”; another described the ward as being “the best ward he had been in, with lots of things to do.” We also heard praise for the SCN “they have really helped me whilst I have been here.”

The OT provision to the ward was highlighted by individuals as being “very good, especially the chance to make meals, fake-aways especially.” We heard that people found environment “spacious, with good areas to relax.”

An individual spoke of his own care planning and said that “things are moving at a good pace.” The individual had a good understanding of their rights under the Mental Health Act, and of their specific treatment plans associated with their care.

We heard that an individual, who will soon be discharged to an open ward in their own health board area, has progressed to have fewer restrictions in their care. Their care plan which will provide evidence to the unit he will be transferred to of his progress towards open conditions and associated risk management. This plan was agreed recently between both wards inclusive of the individuals’ views and that of his advocacy worker and named person. Ward 6 has no delayed discharges but did have an individual who had recently been transferred from another health board area, due to a pressure on beds in the low secure units closer to his home.

We spoke with a staff nurse who described the ward as being a “supportive place to work.” They told us that time was ring-fenced for clinical supervision and that this had improved as the number of nursing staff increased. We heard that the ward currently had a full complement of qualified nursing staff, although there were two vacancies for health care support workers. The staff nurse also told us about opportunities for continuous professional development and what it was like to work in an environment where positive nurse leadership supported ownership of various clinical tasks in the ward, in the areas of care assurance, recovery activities and therapeutic groups.

We heard feedback from senior nursing staff in relation to recent uncertainty with medical cover, although this appears to have been resolved and was not mentioned as an issue by individuals on the ward.

The OT was able to provide feedback, via email, on the support they received from health care support workers and nursing colleagues in joint work with the OTs and dietetics, that was linked to the Scottish Patient Safety Program (SPSP). There was patient involvement with a “passport to IT” course run by a local college campus.

The OT also advised us of the additional pathways that provided access to educational courses for those in Ward 6, and the development pathways from Ward 6 to Ward 7c. This change of environment supported access to safe kitchen practice and use of sharps.

Ward 6 helped individuals develop skills in self-catering that included preparation of their food that does not require any cooking, use of the microwave, oven/cooker and other kitchen equipment. The level of complexity of tasks had helped to test risk. This variation of activities promoted forward thinking, and recovery-focused care supported by a positive MDT approach.

In our report in October 2023, the Commission noted that there were some concerns with food that was being provided for individuals. The issue mainly related to the arrival time, with meals arriving a little early. For example, lunch could arrive at 11:30 am. This has been an on-going issue that the SCN has continued to try and improve. This has been some improvement at times but remains inconsistent. No individuals raised this on the day of our visit but was an action for the SCN to resolve. We were assured that this has been escalated and further discussion would take place to find a solution that would benefit all on the ward. We look forward to hearing how this has progressed when we next visit.

We heard that individuals on the ward had participated in the Scottish Mental Health Arts Festival and that there were plans to be involved again at this year's festival.

Ward 6 benefits from excellent nursing leadership. We found evidence of attention to detail and a dynamic approach to MDT working. This is a secure ward, although it was clear from what we heard from those that we spoke with that they felt engaged with their recovery and in the decisions relating to their care; they were positive about their care, they told us that they felt included and respected. Previous challenges around patients' needs and access to the internet had been escalated appropriately to find the least restrictive solution, supported by NHS Ayrshire and Arran's clinical governance structure. Decisions around care and treatment were evidenced based with records of senior staff seeking best practice solutions.

The SCN discussed these concerns and that had previously it had been raised in the ward when individuals had attempted to access specific adult only sites on the internet on the ward. None of the individuals raised any concerns about limited access to the internet during this visit. Since our last visit, there has been a system put in place that allows individuals to access their own mobile phones. This is risk assessed and documented in risk management plans, that includes the individual's views, which is then shared at the multidisciplinary team (MDT) meeting, and included in care programme approach (CPA) reviews. The Commission have developed a good practice guide, Consenting adults: capacity, rights &sexual relationships.

Sections 9 and12 in this document may be helpful when considering managing individuals' sexual needs and behaviours when they are inpatients.

We were advised that there was a short life working group in relation to individuals use of personal devices for internet access while in Woodland View; the SCN for Ward 6 has not been involved in this. The Commission will follow up on this work and will request a progress update from senior nursing/managers regarding any policy changes related to restrictive practices for individuals.

Care, treatment, support, and participation

Care records

The SCN had arranged for both Commission visitors to have access to the electronic record system, and the electronic prescription system HePMA. Where an individual had only been on the ward for a few days, the SCN had arranged for us to access their paper records.

It was clear to see that there has been a focus on care planning, and that work had been progressed to address the recommendation on care planning from the Commissions last visit. The care plans not only provided detail from a nursing perspective but also involved the full MDT.

We found that all individuals had a person-centred, holistic and dynamic care plan, with evidence of review dates and summative progress notes, describing how all were progressing towards achieving their goals

Records were easily accessible on the NHS Ayrshire and Arrans electronic system, Care Partner. Care plans had realistic and achievable goals linked to CPA reviews, with associated risk assessments and MDT records. Activities and physical health care goals were also included in care plans.

Comprehensive mental health assessments provide detailed clinical timelines of individuals involvement with services. Daily nursing notes were detailed, varied, and contained mental state observations balanced with descriptions of activities/ occupation. Care plan reviews happened at least monthly, with more detailed one-to-one interactions recorded at least every two weeks; the reviews were clear and easy to find.

There is evidence of individual involvement throughout the records.

Multidisciplinary team (MDT)

Ward 6's MDT used the named nurse system, and had input from a consultant psychiatrist, occupational therapy, psychology, social work, and other specific disciplines when required. There was a junior doctor available to the ward for any urgent medical issues. The detailed MDT meeting record noted everyone's involvement in an individual's care and treatment and set out who was invited to

attend the meetings and who had provided an update on their views. The Care Partner system also had a helpful function as it provided specific prompts to ensure key details were captured.

Individuals were 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 the meetings were reflected in the minutes, and these were recorded promptly and accurately, ensuring that all staff were kept informed. Their advocate or legal representative could also attend if required, and individuals could tell us what was in their care plan and how this linked to their progress in treatment.

Where appropriate, there was evidence of input from specific disciplines including physiotherapy, psychology and speech and language therapy. Social workers who worked with forensic patients attended MDTs and CPA meetings and were in attendance when discharge planning began, helpfully when this was at an early stage.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). A further three people were being treated under the Criminal Procedure (Scotland) Act 1995. Two individuals were detained with compulsory orders with a restriction order.

All individuals that we spoke with had a reasonable understanding of their detention status, and the rights in relation to this. Individuals said that access to advocacy and legal representation was easily arranged, and this was documented in their records.

All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment were easily accessible on Care Partner. The legal paperwork was well organised, up-to-date, and corresponded with the Commissions view of what legislation and level of restriction was in place for each person. One individual, who had only been on the ward for a few days had not yet had his legal documentation uploaded to Care Partner although we could access the paper copies of these.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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 had been prescribed.

We found that most psychotropic medications prescribed on HePMA had been authorised either with a T2 or a T3 form. We found one error where a patient had

been prescribed intramuscular (IM) medication on an as required basis on a T2 form, in addition to anxiolytic and other psychotropic medications that had been agreed and authorised. The Commission considers it good practice to have any as required IM medication on a T3 form, not on a T2, as it is unlikely that an individual would give consent to IM medication in an emergency situation. After a discussion with the SCN and consultant psychiatrist this was quickly resolved. The individual had never received this medication and did not require it to be prescribed.

There was evidence of an audit process in place for the T2/T3 forms which could have picked up on this; the prescription was amended on the day. and the medication discontinued.

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 an individual had nominated a named person, we were pleased to note that they were invited to attend CPA and MDT reviews and included in decisions about care.

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. At the time of our visit, there were no individuals who required a section 47 certificate for medical treatment.

Rights and restrictions

Ward 6 operates a locked door policy, commensurate with the level of risk identified with the patient group. There is a small, air lock type entry system overseen by staff.

During the visit we were asked to leave any electronic equipment in a small locker, prior to entering the ward; this system appears to work well. On the Commission's last visit to the service, we heard of the ongoing work in Ward 6 where a review of the level of restrictions that were in place and the proportionality of these was being progressed. Positively, this has led to increased access to social media, opening of the ward area at all mealtimes (bedroom access had previously been limited at main mealtimes) and improved access to the therapeutic kitchen.

It was noted by the ward team that this review had been beneficial to the individuals in the ward, who spoke positively about the changes. However, some decisions have recently had to be adapted, to take into account the level of risk identified on an individual basis.

There were no individuals being nursed on enhanced levels of observations on the day of our visit. The ward staff were aware of the use of continuous interventions,

and we found that historically, this had been documented in nursing notes when required. The SCN spoke of plans to promote this approach further, linking any continuous intervention activity to care plans and activity planners informed by an MDT approach.

Most individuals had access to the hospital grounds, dependent on their clinical progress and risk, and could leave the ward. When they left, they could have access to their own mobile phone, which was signed back in when they returned. This benefited the individual and promoted recovery, with a sense of responsibility. It also acted as a safety measure as staff were able to call individuals should this have been required.

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 individuals were specified for safety and security and the documentation was in order.

When we reviewed files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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. Two patients in Ward 6 had an advance statement, although it was unclear from a review of the notes if the other individuals in the ward had been offered the opportunity to write one. Work to introduce this to the Care Partner system is on-going.

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.

Activity and occupation

We were impressed with the variety of activities and occupation available in Ward 6. Not only was there OT, but the nursing staff participated in providing individuals with a daily variety of activities that improved their physical and mental wellbeing, in accordance with care planning.

Care records noted when there was participation, or not, from individuals and links to recovery care goals were clear. Activities and occupational tasks were appropriate for this group's demographic and were individualised to ensure individual goals were being achieved.

We were pleased to hear that the activity programme had expanded and individuals told us that they valued the range of activities offered by the ward, telling us that it gave them a sense of purpose and value. The Beehive Centre in Woodland View offered regular activity sessions and groups for those individuals in Ward 6 who were able to access them.

There is a weekly meeting between nursing staff and those in the ward, where agreement of the ward-based activity timetable was planned for the coming week. There were regular groups offered, including a newspaper group, anxiety management, fake-away cooking, and a walking group. There was a low intensity psychological therapy group, a therapeutic group exploring mental health, a recovery group, and understanding substance misuse that took place over a 28-week period, or could be individually tailored; this was offered to individuals from Ward 6 and Ward 7c as well as those who were engaging with the community forensic mental health team. Feedback was positive and there was recognition of the benefits of meeting with people from other services.

We were pleased to see that the range of activities has been maintained and improved since our last visit.

The physical environment

The layout of the ward consisted of eight, large, single en-suite rooms. There was a lounge area and dining area that was bright and spacious but with an effort to make it homely. There were two separate smaller lounge areas that could be used if people wanted a quieter space or to make phone calls. There was a well-equipped gym area that was accessible from the main lounge area, and a laundry room that had a timetable for access.

The whole environment was clean and tidy. There were two rooms that could each be locked off if there was a need for seclusion, and there was a seclusion policy in place if required. This space provided a bedroom, separate living room and a separate area for staff to sit, as well as access to the outdoor garden area.

There were two large outdoor areas, accessible to the ward. One was a sports area and the other a garden area. These were well kept and a beneficial area for individuals to use for relaxation, exercise, or gardening projects. Overall, the ward was spacious, well-equipped and filled with natural light.

Individuals and staff alike were positive about the environment of Ward 6.

Individuals with access out with the ward benefited from the other amenities in Woodland View, including the shop, cafe area, library, and psychological therapies hub.

Summary of recommendations

On this occasion, the Commission have made no recommendations; therefore, no response is required.

Service response to recommendations

We would like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved within three months of the publication 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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