Mental Welfare Commission for Scotland

Report on announced visit to:

Woodland View, Ward 7C, Kilwinning Road, Irvine, KA12 8RR

Date of visit: 5 June 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.

Ward 7C is a mixed-gender, ten-bedded rehabilitation unit which provides care and treatment for patients who have been diagnosed with psychiatric illness and may have a history of criminal behaviour linked to their illness. The ward provides full multidisciplinary assessment and treatment for individuals on their journey towards discharge into the community

We last visited this service on 5 June 2021; there were no recommendations made.

On the day of the visit, we wanted to meet with patients and speak with their relatives. We wanted to hear from staff of their experience of caring for patients during the Covid-19 pandemic. This is because we were aware from our previous visit, we had been told of how restrictions had impacted on the ability to access community resources and activities which would improve care and treatment for patients.

As at the time of our last visit to the service, we also wanted to find out if there had been progress made towards developing a more formal referral pathway.

We were keen to hear if the urgent maintenance work that was being undertaken at our last visit was completed and if this meant that patients who did not require rehabilitation services were not being placed in the ward as a temporary measure due to shortage of acute admission beds.

Who we met with

We met with, and reviewed the care of five patients, one who we met with in person and four who we reviewed the care notes of.

We spoke with the deputy charge nurse, members of the nursing team, and an occupational therapist. In addition, we met with the senior manager for inpatient services and the clinical nurse manager at the end of day meeting.

Commission visitors

Mary Leroy, nursing officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with were positive about the care and support they received, describing staff as 'level-headed and supportive'. When we met with patients, they were able to tell us of their experience of care, and there was clear evidence that the patients were knowledgeable about their illness, and potential discharge plans. When we spoke to staff it was evident that they knew patients well and delivered person-centred care. Care plans focussed on individual patient needs, with the involvement of the individual patient evident.

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 every patient's file. This gave an overview of the patient in terms of personal background and support network, the presenting complaint and the mental health assessment, the mental health treatment history and the patient's physical and functional status.

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

Care Programme Approach (CPA) documentation we reviewed was detailed, with evidence of regular reviews. There was input from a range of allied health professionals and we found that patients were fully aware of the content of reports prepared for the CPA meetings. Patient and carer involvement was noted in these meetings, with emphasis put on enablement and recovery. Community workers were involved in planning and staff worked with them, which supported effective communication that ensured patients' needs and skills were recognised, developed and maintained. A forensic social worker was in post and attended all CPA meetings; they linked with each patient's own social worker to ensure ongoing consideration and understanding of forensic mental health needs.

Transition at discharge was carefully planned for, with joint care plans developed with patient involvement and delivered in a thoughtful, staged process.

Staff informed us that they have implemented the 'triangle of care' approach and there was also a carers champion in the ward. The 'triangle of care' is a therapeutic alliance between the patient, their carer or relative and the care team to promote safety, support recovery and sustain wellbeing and ensures that the family know and have ongoing contact with the patient's named nurse and are involved in their care in a meaningful way. Staff reported it could be difficult to engage carers in a more formal carers group, or specific activities, but there was clear evidence of carer involvement and close liaison with them highlighted throughout the notes.

Nursing notes were of a high standard and there was good documentation of liaison with patients and families. There was evidence of one-to-one meetings between patients and nursing staff and these were linked to the goals and interventions detailed in care plans. Care plans contained goals that were person-centred and were directed by the patients, in their own words. Interventions were appropriate and easily followed, with regular evaluation which included the patient and where appropriate carers and third sector providers.

Multidisciplinary team (MDT)

The MDT meetings are held on a weekly basis. The clinical decisions that occurred during these meetings were detailed and clearly documented; they generated an action plan with outcomes and treatment goals. The meetings evidenced patient involvement and attendance. The patient we met with spoke about their involvement in the decision-making process, and it was clear from reviewing the minutes of other patients that they led a lot of the discussion in the meeting and influenced their care decisions. There was ongoing involvement of psychology in supporting the care and treatment of all patients. The psychologist supported the development of a 'staying well plan', through both individual and group work. This focused on psychological wellbeing and aspects of recovery and was used to support the transition to passes out of the ward environment.

Pharmacy was involved in the treatment plan and had developed a staged medication pathway for patients to enable independence in medication management, where possible. This staged plan was used in a flexible way, allowing staff to administer some medications but patients to self-administer others.

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 ('the Mental Health Act') or the Criminal Procedures (Scotland) Act 1995 (CPSA). The patient we met during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act or the CPSA. All paperwork relating to the act was filed appropriately and easily accessed on the electronic file.

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.

Rights and restrictions

There were nine patients who were subject to specified person regulations. 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 was a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

From the records we reviewed, we found the restrictions had been legally authorised in some instances but restrictions for telephone use and those restriction relating to correspondence had not. It was unclear how these restrictions were reviewed and two had lapsed. Evidence of

the reasoned opinion and the appeal process, which should have been provided for the patient, was not documented clearly in the records.

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

Recommendation 1:
Managers and medical staff should review current processes in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

When we were reviewing patients' files, we found several patients had 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. There was evidence patients were encouraged and supported to complete advance statements.

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 everyday schedule of therapeutic activities based in and around the hospital site. Staff had worked hard to ensure patients had access to as many activities as possible and patients had let us know how important this was for their recovery. We were pleased to hear how the activity programme has expanded and links to community groups and vocational opportunities have been re-established and developed.

We were told by patients they value the activities offered by the ward as it gave them a sense of purpose and value. Work opportunities were offered by Coastal Watch, which involves patrolling the coastline and checking surveillance cameras along the coast; one patient we spoke to reported how rewarding he found this. There were links with local church groups and regular groups include cycling, walking and a social shopping & cooking group, which encouraged the social aspects of cooking and sharing a meal. The Beehive activity hub offered regular activity and the physiotherapy department had a swimming group.

We saw that each patient had an activity plan that was personalised to their needs, and that each patient was involved in creating. Thought was put into these plans that ensured that they were based in the community that the patient was to be discharged to. An example of this was where one patient was supported to do all his food shopping at the shops local to his planned discharge accommodation. He reported at the MDT meeting how this had increased his confidence. Staff described how this approach does take more time, but they see the benefit of this in supporting successful discharge.

The physical environment

The unit was purpose built and was bright and clean. It was appropriately furnished with good attention to detail, making sure that it provided as homely an environment as possible. The

kitchen/dining area was spacious and clean, and as patients are expected to self-cater on this ward, there was a great deal of space for storage.

The bedrooms were spacious and had plenty of natural light. Rooms we saw were personalised. The meeting rooms and laundry room were at the entrance to the corridor shared between the two wards.

The garden was pleasant, spacious and well-tended. The garden provided opportunities for activity and a calm outside space for individuals whom, we were told, use it on a regular basis. There were plans to develop a vegetable patch which, it is hoped, will offer opportunities for gardening and to use the produce for self-catering.

Any other comments

Our previous visit had highlighted staff concerns that patients with different needs were being moved into Ward 7C as a temporary measure when there were no adult acute care beds. This had an unsettling effect in the ward as staff were trying to manage different levels of need. We were pleased to hear this is no longer an issue, the improvement work that had reduced bed numbers has been completed and there is a plan to open a vacant ward to accommodate crisis admissions. Staff agree this has created a more therapeutic atmosphere on the ward.

The ward has plans to undertake a quality improvement project focussing on the review and development of outcome measures regarding the following ward specific areas: therapeutic activity and engagement, physical health pathways, patient experience and family/carer experience. This programme will sit as part of a wider programme for inpatient services that sit under North Health & Social Care Partnership. There is also ongoing work to develop a forensic pathway for Ayrshire and Arran which it is hoped will be completed soon.

Summary of recommendations

Recommendation 1:
Managers and medical staff should review current processes in relation to specified persons and ensure all necessary documentation is completed and regularly reviewed.

Good practice

The ward demonstrates excellent holistic care where patients feel empowered to develop responsibility and control for their own health needs and recovery. This was demonstrated in care plans where patients' goals focused on what recovery looked like for them. Physical health concerns such as diabetes or weight gain were linked to self-catering plans and activity programs guided by patient's wishes. A patient told us "this ward is run as a rehab ward should be."

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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