Mental Welfare Commission for Scotland

Report on announced visit to:

Wards 9, 10, and 11, Woodland View Hospital, Kilwinning Road, Irvine, KA12 8SS

Date of visit: 7 September 2023

Where we visited

Wards 9, 10, and 11 are 20-bedded adult acute admission mental health mixed-sex wards. The wards are situated in the grounds of Ayrshire Central Hospital in Irvine and serve East, South and North Ayrshire areas respectively. The wards provide assessment and treatment for adults who have a diagnosis of an acute mental illness and/or behavioural difficulties. On the day of our visit there were four vacant beds.

We last visited wards 10 and 11 in May 2023, and ward 9 in August 2021. Recommendations made were to ensure that treatment was legally authorised, for partner agencies to expedite discharge, one-to-one nursing discussions were to be clearly documented and highlighted, and that wards should have access to copies of guardianship orders, and these were filed appropriately. On this visit, we wanted to follow up on these recommendations and hear about any progress made. We were also keen to meet with individuals in the ward, their family and carers, and members of staff.

Who we met with

We met with, and reviewed the care of 22 patients, 21 of whom we met in person and reviewed their care notes, and one where we reviewed the care notes only. We also met with one relative.

We met with nursing staff, student nurses, and a psychiatrist. We spoke with the service managers and the senior charge nurses who were able to provide an update prior to our visit.

Commission visitors

Margo Fyfe, senior manager, West Team

Kathleen Taylor, engagement & participation officer

Justin McNicholl, social work officer

Sheena Jones, consultant psychiatrist

Andrew Jarvie, engagement & participation officer

Mary Leroy, nursing officer

Gemma Maguire, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Throughout the visit, we saw kind and caring interactions between staff and individuals; staff we spoke with knew the patient group well. It was good to note that the individuals who we met with praised the staff highly, saying they were very well looked after, commenting that they felt listened to and that staff had time to talk and take an interest in them. There were comments that the nurses were 'friendly and helpful' and 'focus on helping me recover and get on with my life'. We were told '90% of the time the care is exceptional'; some individuals reported that care was not delivered in a consistent way when there are bank staff on duty. This seemed to be a particular issue in relation to physical care or support through the night. One person had had an issue with the way they were spoken to by a bank nurse. When they raised this with permanent staff it was dealt with appropriately and the person felt supported and listened to.

The feedback about the food in the ward was mainly positive with many individuals we talked to describing it as 'great' and 'very good'; individuals were pleased that their dietary needs were well catered for.

We did hear feedback from some individuals that they would like to meet their doctor on a one-to-one basis, but this is difficult to organise. They reported seeing them in the team meetings regularly, but some found this a difficult forum to talk in and said they would prefer an individual meeting. In Ward 11, we heard from some individuals that they had not had their care reviewed by a psychiatrist for over two weeks, due to medical staff absences. We discussed this with the senior charge nurse who agreed to follow this up with medical staff on the day of the visit.

Nursing staff appeared motivated and reported enjoying working in the wards. They were able to knowledgably answer all queries that we had on the day and were aware of the importance and opportunities for supporting patients' rights.

Care, treatment, support, and participation

We found that patients across the three wards were at different stages of their recovery journey. We were told that some patients had recently been admitted to the wards, and others had been in for a longer period. There were 12 individuals across the three wards whose discharge was delayed. These delays were caused by difficulties in accessing appropriate placements and/or care packages. In our last visit to Ward 9, we had recommended that managers should ensure that work continues alongside partners to expedite discharge. We were pleased to hear that the hospital was proactively managing these delays through weekly meetings with colleagues in the health and social care partnership and through regular reviews of each individual's needs. We found that the outcome of these meetings was not always included in ward reviews.

Due to increased levels of risk and acuity of mental ill heath, some patients had been placed on continuous intervention and required a higher level of staffing involvement. We were told that there were more patients in Ward 9 who required support with their physical healthcare needs, which placed a greater demand on nursing time.

We found that risk assessments were comprehensive, reviewed regularly and they had an individualised action plan that considered the assessed risks.

We reviewed the care plans and found them to be person-centred; they reflected the needs of the individuals and had been developed jointly with the patient. A new care plan was created each time staff reviewed the existing care plan. This made assessing the success of the interventions and reviewing the progress towards the initial goal more difficult. We found the work on care planning undertaken in Ward 10 had addressed this issue and the care plans in this area were of an excellent standard. We would suggest the learning from this area is shared with the other wards.

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 had some difficulty identifying the one-to-one discussions in the notes, although a flagging system has been developed as part of the Scottish Patient Safety Programme. This allows easy identification and review of one-to-one meetings which would allow staff to update themselves more easily on an individual's progress. We were pleased to hear there were plans to include this flagging system across wards in Woodland View and look forward to seeing this on future visits to the service.

We saw that physical health care needs were being addressed and followed up appropriately, with people supported to link to their local community services where appropriate.

Multidisciplinary team (MDT)

The wards have a broad range of disciplines either based there or accessible to them. The multidisciplinary team (MDT) on site consists of nursing staff, psychiatrists, occupational therapy, pharmacy and psychology staff. Referrals can be made to all 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 give an update on their views. This also included the individual and their families, should they wish to attend. We felt it would be helpful to also include the details of people who had been invited but did not attend.

We were concerned to hear from individuals in Ward 11 that they had not had a review by a psychiatrist for over two weeks due to medical staff absence; this was evidenced in the care notes. We also heard in patients in Ward 10 did not feel they could access individual appointments with their registered medical officer (RMO), and we could not find one-to-one meetings with the RMOs in the care records.

Recommendation 1:

Managers should ensure there is robust cover when registered medical staff are absent and reviews are required to be carried out in a timely manner and clearly documented in care files.

There was clear evidence of occupational therapy and physiotherapy involvement in individuals' notes along with activity and care plans. One patient described the physiotherapist as 'the hero of my journey'.

We heard that there was now a full-time psychologist in post who divides their time between the three wards. Staff reported that the formulations completed for individuals had been helpful in supporting staff to develop more meaningful interventions; they had provided staff with an increased understanding of the factors that had influencing the person's presentation.

We thought that in some individual's circumstances, care could have been enhanced by the involvement of speech and language therapy, to ensure communication was appropriate and fit for purpose, particularly for those with a diagnosis of autism spectrum disorder. We also thought that occupational therapists could support the development of an assessment of the sensory needs of these individuals. This would then aide staff to ensure the environment better met the individual's needs. A previous recommendation in 2019 had been that managers should ensure that staff who were involved in the care of a person with autism and complex needs should be trained to the appropriate level of the NES training framework. We discussed this with managers on the day and were told that there had recently been significant staff turnover and that there were plans to provide specific training to staff in the wards on neurodiversity, which they would be supported to complete. We look forward to hearing how this has progressed when we next visit.

Information on patients care and treatment was held on the electronic record system, Care Partner. We found that when the system was opened on a person's record it flagged up any alerts relating to legal status, protection issues or other warnings. This was helpful and a good way of ensuring staff were aware of key information. However, we found that there was some information missing from individuals' records, and in some cases the alerts had not been created. We discussed how good practice and innovations from one ward could be shared through the hospital site, and we were assured that discussions are ongoing with the electronic notes group to ensure that successful pilots are embedded into the system for all wards to use.

Use of mental health and incapacity legislation

On the day of our visit, 27 of the 56 patients in the wards were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patients we met with during our visit had a good understanding of their detained status under the Mental Health Act.

All documentation relating to the Mental Health Act and the Adults with Incapacity Act (Scotland) 2000, including certificates around capacity to consent to treatment, were in place in the paper 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, but in some cases, they did not correspond to the medication being prescribed. We highlighted the instances where medication was prescribed but not included on the T3 certificates and requested that the responsible medical officer update these as a matter of urgency. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date. A previous recommendation had been made for managers to ensure consent to treatment

certificates were audited to ensure treatment was legally authorised. Though we found certificates were in place, all medication was not included and therefore not legally authorised.

Recommendation 2:
Managers should audit authority to treat documentation to ensure that treatment is legally authorised.

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 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 s47 certificates were in place for all individuals who required one, although in two cases, there was no accompanying treatment plan. However, we found an exemplary completed certificate which was person-centred and clearly showed a decision specific capacity assessment alongside a robust treatment plan. The responsible medical officer had reviewed the certificate within 1 month, by which time the person had regained decision-making capacity, and the certificate was discontinued.

Rights and restrictions

When we reviewed patients' files, we looked for copies of advance statements. The term 'advance statement' refers to a written statement, made under sections 274 to 276 of the Mental Health Act, which is written when a person has capacity to decide on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. On the day of our visit, we were unable to locate any. Advance statements are a way of ensuring that people with mental ill health are listened to and have their human rights respected. We would like to have seen evidence of the attempts made to engage patients in a discussion regarding advance statements, particularly in the discharge planning process and the reason noted for any patient that does not have one.

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. We found that there were two people who were specified: one for safety and security, and one for both safety and security and for telephone use. All appropriate legal authority was in place and reasoned opinions recorded in their notes. The individuals involved had been made aware of their right to appeal this decision.

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

One person that we spoke with during our visit reported to us that they believed that they were 'not allowed' to leave the ward for any time out when first admitted although they were not detained. When we discussed this with staff on the day, we were advised that on admission, staff can, through consultation with the individual and with their consent, restrict time off the

ward or advise that only escorted time off is possible. This was usually in conjunction with respective risk management assessment and plan. We advised the care team that this needs careful documentation and care planning to ensure these restrictions are legally consented to.

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

The wards all had either a dedicated activity nurse or have nurses that were allocated to organising activity. There was evidence of activity timetables in the ward and of the activities that individuals were able to take part in on the ward.

We were pleased to hear that the patients again have access to the Beehive activity hub; we were informed that during the pandemic there was no access to the service. We were told that due to some restrictions caused by Covid-19, the level of activity provided by the Beehive had been adversely affected. However, through the remobilisation process, patients were beginning to engage and have access to a wider variety of activities that were available, although this has not returned to pre-pandemic level. Staff noted the feeling of community is not the same in the hub, as wards still have to attend separately.

The physical environment

Each ward consists of 20 single en-suite rooms.

The entrance provides a warm and welcoming introduction to the ward. Meeting rooms, which were offset from the foyer, enable visiting families and professionals to meet in these rooms without having to walk through the ward. There is also a small visitors room. Homely furnishings were evident. Throughout the wards there are quiet spaces and a wide variety of places and opportunities to meet with people.

There is a lounge area and dining area in each ward, both are bright and spacious. The environment was immaculate, and we were told repairs are carried out promptly.

Each ward has its own self-contained courtyard area, all of which are well-kept, have plenty of sitting areas and are easily accessed by individuals. We were informed there is lighting which means it can be accessed throughout the evening. On the day we visited, all the garden areas were in use.

Any other comments

We were impressed on the day of our visit by the professional and knowledgeable staff in the wards. Strong leadership was evident at both ward level and in the management team. Staff have been encouraged to develop improvement programmes in their ward areas, supported by the hospital improvement team and the Scottish Patient Safety Programme, and it was clear this work has created opportunities to improve the care and treatment for patients across the three wards. We look forward to seeing how this work develops across the wards to allow the learning and improvements to be shared on our next visit.

Summary of recommendations

Recommendation 1:
Managers should ensure there is robust cover when registered medical staff are absent and reviews are required to be carried out in a timely manner and clearly documented in care files.

Recommendation 2:
Managers should audit authority to treat documentation to ensure that treatment is legally authorised.

Service response to recommendations

The Commission requires a response to these recommendations within three months of 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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Mental Welfare Commission 2023