Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 7a, Woodland View Hospital, Kilwinning Road, Irvine, KA12 8RR

Date of visit: 3 July 2024

Where we visited

Ward 7a is a seven-bedded (formally eight, although reduced by one to provide more space for managing patients in distress), mixed-sex ward that provides assessment and treatment for individuals who have a learning disability, with significantly complex health care needs.

Ward 7a is located in Woodland View in Irvine, Ayrshire; it is a bright, airy, and attractive building that provides patients, relatives, carers and staff with a café, shop, atrium, and other facilities which offer opportunities for relaxation, therapeutic group work or learning.

Who we met with

Prior to the visit, we held virtual meetings with the service manager, deputy charge nurse (DCN) and senior charge nurse (SCN). There had also been a meeting with the general manager and some of the senior nursing team who cover NHS Ayrshire & Arran mental health service in general.

On the day of the visit, we met with the senior manager, the SCN, and nursing staff on the ward. We were also able to meet with one of the consultant psychiatrists for the ward, the occupational therapist and the service manager. The senior manager joined us for feedback at the end of the day of the visit.

We met with three individuals and undertook file reviews into the care and treatment of all seven people residing in the ward. One of these meetings took place on the telephone as the individual was on pass at the time of the visit. Due to the mental state and acuity of some patients, they were unable to engage in discussion with the Commission visitors. However, we were able to observe how care and treatment was delivered to individuals on the ward.

We had a telephone discussion with relatives for two individuals on the ward.

Commission visitors

Paul Macquire, nursing officer

Mary Leroy, nursing officer

Gemma Maguire, social work officer

What people told us and what we found

This was an announced visit, so individuals and staff were aware of our visit and happy to meet with the Commission staff. Senior staff had, helpfully, prepared all relevant documentation for the Commission staff to review and had asked individuals and families/carers/advocates if they wished to speak with the Commission visitors on the day.

Overall, the individuals we spoke with were very complimentary about the service, the staff, and the care that they had received. There was a positive focus on therapeutic and caring relationships with staff and we heard, specifically, from those that we spoke with, and a family member about the work of the senior charge nurse (SCN). One patient stated, “The SCN is very good, supportive and helpful” and “any issues I have raised, they have investigated and resolved these.” The consultant psychiatrist, was also singled out for praise when an individual commented that the doctor was “very transparent, helpful and keeps me involved in my care.” A family member who is now supporting their relative towards discharge wanted to highlight that the social worker has been “very good and puts themselves out for my son’s care.” When a carer was asked about the most significant changes to their relatives’ care, they replied by saying “the main thing is, I don’t need to worry about him now.”

The ward is supporting a partnership approach to the provision of care and treatment, and the staff encouraged relatives to be as involved as they wished to be in relation to their loved one’s care. We found that staff were dynamic and thoughtful in all aspects of care planning. We were pleased to see that staff used visual aids to support communication and inclusive decision-making. We found that for those with significantly stressed and distressed behaviours, in some instances, these episodes had reduced significantly with the person-centred care provided; this had also reduced the need for physical restraint and has been pivotal in facilitating patients to communicate and form healthy attachments with staff.

We found that the trauma informed practice, delivered by the whole multidisciplinary team (MDT) was exemplary. There were active positive behavioural support (PBS) plans, and life journey journals supported by Glasgow School of Art that further evidenced this practice. The Glasgow School of Art have been involved in producing the document *Celebrating Patient Journeys within a Learning Disability Assessment and Treatment Ward*. This notable piece of work was made available to the Commission visitors on the day.

Every individual on the ward was cared for using the care programme approach (CPA). CPA is a framework used to plan and co-ordinate mental health care and treatment, and it encourages a joined-up approach to MDT working and improves communication between disciplines.

The ward was appropriately staffed on the day of the visit and staff were positive around their experiences of working in the environment. We were advised that there were two trained nurse vacancies, although it was positive to note that all trained nursing staff on the ward were registered learning disability nurses (RNLD); other areas have struggled to maintain their compliment of RNLD nurses, and use registered mental health nurses (RMNs) to fill vacancies. Bank staff continue to be used when required, with agency staff used only occasionally. Individuals on the ward clearly benefit from working with the same group of nursing staff over longer periods of time.

We met with the OT who provides input to the service three days per week. The OT is also part of the 'intensive support service', providing a link from the ward to community recovery services. This is a multi-disciplinary team developed by North Ayrshire Health and Social Care Partnership to focus on recommendations of the Coming Home report *Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge* (www.gov.scot), given previous issues with 'out of area' placements, complex care, and delayed discharges. This team specifically provides input to those funded by NAHSCP who are currently delayed discharge. It is also reassuring that those being discharged to NAHSCP funded placement will receive ongoing input from this service, which will support transition to community supported living placements. The OT collates views directly from individuals that have supported development of the activity program. The OT has also secured an afternoon, one day per week, at a local community garden, where two individuals from the ward attend and there are plans to support engagement of more individuals. The OT was also supporting activities, along with nursing staff, such as swimming, cooking and working with individuals to develop a monthly newsletter and in assisting a patient in setting up an information stall for mental health awareness.

There was a focus on delayed discharges, with the service ensuring that escalation and scrutiny was in place using the local delayed discharge procedures and a dynamic Support Register it was clear from the documentation and discussion with the Commission visitors that senior managers had progressed with work around those patients who were deemed as clinically fit for discharge in working with the appropriate local authority (LA) to source appropriate placements. It was positive to hear that for some individuals with complex needs, community placements had been identified with discharge planning progressing at an advanced phase.

Since our last visit to the ward which took place two years ago, we were pleased to note that the dynamic and progressive work of the service has meant that for some in the ward, they have been supported to move on to a community setting in the very near future. Although nearly all individuals in the ward were considered to have their discharge delayed, there was a clear focus on discharge planning in this ward. The Commission visitors recognised that staff actively promoted a holistic, caring, and diligent approach to discharge planning, however where there have been opportunities to move patients on, the MDT have come together to recognise that for some identified placements, these would not have been an effective environment that would have sustained an individual's recovery in the community.

Care records

Care records were detailed, person-centred and contained each individual's views alongside that of carers, relatives and/or guardians. We found evidence of improvements in the recording of progress towards meaningful individual goals, an area where the Commission had suggested improvement during our last visit.

The Commission last visited in June 2022, and made a recommendation that a process for auditing care plans was put in place. On this visit, we found the standard of care plans, developed and maintained on NHS Ayrshire & Arran's electronic system for care records, Care Partner, to be excellent; we found the information on Care Partner was easily accessible.

Each care plan was professionally written, inclusive and linked clearly to PBS plans and risk assessments. Care plans were reviewed regularly and we saw evidence of a care assurance audit, with both qualitative and quantitative data, demonstrating evidence of assurance that quality care was being provided and maintained.

Multidisciplinary team (MDT)

On the day of our visit, there was clear evidence of strong nursing leadership, supported by an MDT that included consistent and constructive input from the consultant psychiatrists, alongside dynamic and varied activities planned by the OT, with positive involvement from psychology and pharmacy to the ward.

The MDT approach to care was clearly evident on the ward. MDT notes were available and written in a consistent and progressive way. MDT discussions took place regularly and all stakeholders, including individuals were invited to attend. Decisions were clear, concise and appear to be well communicated.

OT, psychology, and pharmacy contributed to care that was delivered, and the MDT note highlighted where all professionals and individual attended or not. We found that this provided holistic consideration and planning of each individual's needs.

CPA documentation was detailed, with evidence of regular reviews. There was input from a range of allied health professionals that was evident in the records. It was clear from discussions that individuals were fully aware of the content of reports that had been prepared for their CPA meetings. There was evidence of individual and carer involvement in these meetings, with emphasis put on enablement and recovery and the involvement of the local Community Learning Disability Team.

Use of mental health and incapacity legislation

On the day of our visit, all individuals on 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 (CPSA). 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 individuals, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates authorising treatment (T3) under the Mental Health Act were in place for all individuals, 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 (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. Where required, this was evidenced on the day of our visit.

The AWI records were easily accessible, with sections on capacity and legal safeguards such as section 47 certificates, copies of guardianship orders, the contact details for guardians and any arrangements that were in place for both welfare and financial decisions.

Rights and restrictions

Ward 7a operates a locked door, commensurate with the level of risk identified with the group of individuals receiving treatment.

Where specified person restrictions were required 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 an individual is a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied. For those individuals in Ward 7a who were specified for safety and security and use of the telephone, we found that the documentation was in order.

On the day of the visit, two individuals required care with enhanced observations. We found evidence of this in care planning, the PBS plan, and the CPA documentation. We were able to access a detailed example of a Red-Amber-Green light escalation system, which was person-centred and highlighted the specific needs of the individual and what may trigger an escalation in behaviours. Furthermore, there were clearly documented details of what response would help reduce any associated risks during these times of increased stress and acuity.

We were pleased to note that advocacy was available to all, and patients, relatives, carers, and advocates were encouraged to participate in decision-making around care and treatment.

The physical environment

Ward 7a is a small ward, not originally designed for treating individuals with LD and autistic spectrum disorder. Nevertheless, the ward offers a bright and pleasant environment that has been made homely and comfortable by staff. There are large single rooms with en-suite facilities.

There is access to outside courtyards that are well maintained, with seating creating a pleasant outside space. However, staff highlighted that given some of the challenging behaviour that can occur on the ward, individual safety and a positive milieu is often an important consideration when deciding who utilises which room at any given time. The limited space on the ward makes the practicalities of day-to-day living challenging and this was raised by the clinical team on the day of our visit; they wanted to highlight the impact of the limited space in the ward.

Ward 7a was not designed in a bespoke way for individuals who have additional sensory needs because of LD and ASD. Because of this, there can be additional stress and distress that is unnecessarily placed on individuals, due to the limited number of areas where people can be cared for in a way that would reduce stimulus. With individual rooms being so close, when one individual becomes overwhelmed, this can impact the wellbeing of others on the ward.

In addition to this, a small dining room and a lack of space for quiet areas or sitting area space means that individuals often must use these spaces one at a time. On the day, we saw evidence of broken furniture from individuals becoming distressed. This furniture had been repaired using tape and appeared to present a hazard for this group of individuals and staff. Where enhanced observations were taking place, this used a space that was part of another ward and this appeared to work well as a temporary solution.

The ward has a quiet/ sensory room with bean bags and other equipment for reducing sensory distress, however, the windows were blacked out using black bin liners; some of these were missing from the windows.

The original staff office was outside of the ward, so staff are currently using a room which was previously a bedroom, and this has not been adapted to reflect the change in use. The bed space was being used to store papers and there was limited storage on the wall. This could be adapted to reflect its current use as a staff office.

Recommendation 1:
Managers should review the environment to ensure that it appropriately meets the needs of the current group of individuals being cared for.

Summary of recommendations

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Service response to recommendations.

The Commission requires a response to this recommendation within three months of the publication date of this report. We would also 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. This has been added to the action plan.

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.

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