Mental Welfare Commission for Scotland

Report on unannounced visit to:
Ailsa Hospital, Dunure Ward, Dalmellington Road, Ayr, KA6 6AB

Date of visit: 23 May 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Dunure Ward is a 14-bedded, mixed-sex ward for adults on the Ailsa Hospital site in Ayr. The unit provides hospital based clinical complex care for adults who have a functional psychiatric illness.

On the day of our visit, there were 12 people on the ward and there were two vacant beds.

We last visited this service in August 2022 on an announced visit and we made no recommendations.

For this unannounced visit we wanted to speak with individuals, relatives/carers where possible, and staff to hear the views and experiences on how care and treatment was being provided on the ward

Who we met with

We met with, and reviewed the care of eight people, four of whom we met with in person and four we reviewed the care records of. We did not meet with or speak to any relatives.

We spoke with the deputy charge nurse (DCN), two staff nurses and a nursing assistant. We did not meet with any allied health professionals.

Commission visitors

Anne Craig, social work officer

Dr Sheena Jones, consultant psychiatrist

Dr Catriona Neill, ST6 LD Psychiatry Trainee

What people told us and what we found

Care, treatment, support, and participation

A few of the people we spoke to were able to provide a view of their care. One said “staff are pretty nice,” another told us that “staff look after me” and when asked about activities they said there was “too much to do”. They also said that the doctor was “quite nice” but that they needed a new social worker (social worker had been invited to recent ward meeting).

Other people, due to cognitive impairment, were unable to make any comment.

Throughout the visit, we observed positive, compassionate and helpful interactions between staff and individuals and the staff that we spoke with knew people well.

Care records

Electronic records were stored on Care Partner; there were no information held in paper files. Care Partner was easy to use and information was readily accessible. The records that had most recently been inputted to the system were immediately available.

The care plans were holistic, person-centred, detailed and reflected the goals and objectives for individuals. It was difficult to find previous care plans when there had been an update however, staff were able to demonstrate on the day how to review older versions of the care plans so that we could see the changes from the original plans.

We could see that care plans linked well to the discussions and decisions at the weekly multidisciplinary (MDT) meetings. There was evidence of discussions with families in the MDT notes, where appropriate.

We also noted that care plans were in place where there were concerns about physical health. These were detailed and included actions that could/should be taken when a person may become physically unwell. During our visit, we observed care being given to a person who was physically unwell and noted the efforts of nursing and medical staff in response to this situation.

We were told that care plans should have been reviewed monthly, however, we noted that two were overdue. This was brought to the attention of the DCN for immediate attention.

Risk assessments were detailed, up to date and reflected a person-centred approach; the care records and MDT discussions were informed by information from the risk assessments.

We noted that some people had do not attempt cardiopulmonary resuscitation (DNACPR) in place and on review felt that these were mostly appropriate in reflecting

the physical health of the individuals. We did highlight that there was one individual whom we felt that DNACPR was not appropriate and asked that this be conveyed to the responsible medical officer (RMO) for further consideration. We will follow this up with the RMO.

We asked about anyone whose discharge from hospital may be delayed and were pleased to hear that at this time, there were no individuals who were affected by this. We asked that for those receiving hospital-based complex care, they should be kept under review, usually every six months, using the criteria "can this individual's care needs be properly met in any setting other than a hospital?". This decision is the responsibility of the RMO.

Earlier in 2025, two people had moved on from the ward, one to a care home placement and the other person returned home. We discussed one person with the nurse in charge whose care and treatment needs were well understood, presentation was stable, and we felt that it may be possible for their care to be provided in an alternative setting. We will follow this up with the RMO for further consideration.

Multidisciplinary team (MDT)
The multidisciplinary team consists of psychiatry and nursing staff. Referrals can be made to all other services as required. We saw evidence of advocacy being involved with people and this was recorded in the notes.

MDT notes were on file and recorded attendance, the individuals' presentation since the last meeting, consideration of any continuing health needs and health risk assessments. There were discussions with the MDT about the ongoing need for hospital based clinical complex care.

We saw evidence that people were asked to attend the MDT or for their opinions about their care and these were recorded in the records. We thought that there could be reference made to who would be responsible for actions that had been agreed at the MDT although we acknowledge there are some difficulties with this due to staffing.

Use of mental health and incapacity legislation

On the day of the visit, five people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Five people on the ward were informal patients and three were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) such as a welfare guardianship or power of attorney.

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 being prescribed. We did find that there were discrepancies on two of the certificates authorising treatment (T3's). This was followed up on the day of the visit with nursing staff.

Recommendation 1:
Managers should ensure medication records are reviewed for patients requiring forms (T2 and T3) authorising treatment under the Mental Health Act.

All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment were available.

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. We found one s47 certificate which had expired a week prior to our visit. This was brought to the attention of the nurse in charge of the ward to be immediately rectified.

We reviewed the existing s47 certificates and felt that the detail contained in the treatment plans was insufficient. Treatment plans should be written to include all healthcare interventions that may be required during the time specified in the certificate.

Recommendation 2:
Managers should ensure that treatment plans are completed correctly with sufficient detail of the interventions that may be needed during the lifetime of the s47 certificate.

Any individual 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 did not find any named person documentation. We asked the DCN and they advised that one individual had a named person but this was not recorded on the file; this was amended at the time of our visit.

For those people that were under the AWI Act we found copies of power of attorney and welfare guardianship documents on file.

Rights and restrictions

The main door to the unit was locked in the safety and security of the people in the unit. Staff were available to allow entry and exit to visitors as required and there was a reception at the entrance to the wards where visitors could be assisted with entry and exiting the unit.

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 made a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit there were no specified persons on the ward.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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. We found one person had an advance statement on file. Due to the needs and impact of illness for those individuals in the unit, we would not have expected that promoting advance statement completion was appropriate.

We did consider that for one individual, they may have been "defacto detained" as there were no safeguards in place in relation to the restrictions imposed on them; we will discuss this further with the RMO.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

The unit does not have a dedicated activity co-ordinator. The deputy charge nurse explained this model was previously in place but due to the need for activities to be person dependent worked with an activity co-ordinator model and there are challenges with this as it is person dependent. There is a designated lead allocated on the shift planner each day for activities and is felt to be the preferable model. Records show that people are regularly offered activities and we heard that staff tried hard to ensure that patients were active and engaged during the day.

We noted that in the care records there were strategies used at times of stress and distress. These were person-centred and reflected approaches that were known to have a positive effect.

We heard that people could go on outings from the ward if they were fit and well enough. We heard that one person enjoyed going for a walk and for outings in the car; we noted there had been a recent visit to a local attraction.

We also heard that some people would indicate a wish to go on outings but would then decline this when it was offered. We saw records of when people engaged in

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

activities and when they declined to be involved. We saw an activities board in the communal area with twice-daily activities that had been identified and we viewed the garden area, where people were encouraged to use their gardening skills and were supported by the staff team.

We saw people in the garden enjoying the weather and others in the lounge watching television. People could use digital equipment to stay connected with their loved ones and were supported by the staff team where this was required.

There were no restrictions to freedom in the ward setting and people were able to move around without restriction.

The physical environment

The unit is bright and airy and has a homely feel with good personalisation in rooms as far as possible. There was a high standard of cleanliness and domestic staff were included as part of the ward team.

The large communal area off the ward was pleasant and provided an area for social occasions, group work and family visits for all individuals.

Summary of recommendations

Recommendation 1:
Managers should ensure medication records are reviewed for patients requiring forms (T2 and T3) authorising treatment under the Mental Health Act

Recommendation 2:
Managers should ensure that treatment plans are completed correctly with sufficient detail of the interventions that may be needed during the lifetime of the s47 certificate.

Service response to recommendations

The Commission requires a response to these recommendations 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 an individual's care, treatment, and support are 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.

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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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