



**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:** Clonbeith ward, Ailsa Hospital, Dalmellington Road, Ayr KA6 6AB

**Date of visit** 30 May 2017

## **Where we visited**

Clonbeith is a 15 bedded ward for male and female adults on the Ailsa Hospital campus in Ayr. The ward provides assessment and treatment for individuals over 65 who have complex care needs, functional psychiatric illness, and with stressed and distressed behaviours. As part of the continuing redesign of the inpatient and community services in NHS Ayrshire and Arran, there is a process of resettlement and re-provisioning of services for the patients on the Ailsa site. We were keen to hear how this was progressing. The senior charge nurse (SCN) also informed us there had been some initial discussion on this move, more recently there has been some further consultation with the senior staff and there are plans for future events to engage with patients' families and carers to hear their views regarding the future plans for this service.

On the day of this visit we wanted to review the care and treatment being received by patients, including activity provision and physical health. Clonbeith is one of the six wards remaining at Ailsa Hospital since the transfer of the other wards to Woodland View Hospital in Irvine. We were concerned about the impact this situation had on the service. We wondered if this had impacted on service delivery, specifically ward resources, and whether staff felt sufficiently supported to deliver care and treatment to a high standard. We therefore wanted to meet with patients, carers and staff members to hear their views.

## **Who we met with**

We met with six patients and reviewed their notes. We also met with the relatives of two patients. We spoke with the SCN and several members of the nursing team.

## **Commission visitors**

Mary Leroy, Nursing Officer (visit coordinator)

Mike Diamond, Executive Director (Social Work)

## **What people told us and what we found**

### **Care, treatment, support and participation**

The majority of all patients and relatives who we talked to during the visit spoke positively about the care and treatment provided by staff in the ward. We heard specific comments about staff being approachable and friendly, and we observed positive interactions between staff and patients during the time we spent on the ward. The staff told us of the strong team they feel they have, which they believe contributes to the care and treatment received by the patients.

Care plans were person-centred and detailed in terms of physical and mental health. The care plans included building strengths and abilities and taking into account the

patient's own goals and interests. It was also clear from interviewing the staff that they knew the patients well and all care and treatment was appropriate to the patient's current needs.

There were excellent examples of anticipatory care plans. These are most commonly used to support people living with long term conditions in order to plan for an unexpected change in health or social status. The care plans evidenced the evolving conversation, collaborative interactions and shared decision making between patients, families and the multidisciplinary team (MDT). We were also informed by the SCN that the service had been nominated for the Ayrshire Achieve Award in two categories: caring for people and the team of the year award for 2017. The team await information to see if they have been shortlisted for the awards.

Patient involvement in their care is evidenced through participation in the ward review and in the compilation of care plans. We met with two patients who were ready for discharge. They informed us they had been involved in the planning for their discharge which included: assessment of risk by occupational therapist (OT), arranging home visits, plans for follow up and also clinical interventions they would be participating in prior to discharge. During interview both patients had a clear understanding of their discharge plan.

There is a monthly community meeting held within the ward. During those meetings the patients have the opportunity to discuss issues and concerns regarding their care and treatment, also to put forward and have input regarding ideas for ward activities.

The advocacy service within the ward is available on a referral basis. There was an information leaflet on display and available on the ward. We were told there is good advocacy input to the ward.

The MDT meetings occur once a month, they are attended by all members of the team. The meetings are well documented and generate a clear action plan that is also reflected in the patients' dynamic care plans.

All patients are offered the opportunity to attend the multidisciplinary meetings. For the patients who do not attend their issues and views are raised at the meeting and there is feedback from the meeting by medical or nursing staff. We saw evidence of these discussions in the MDT information held within the chronological notes.

There is a clinical psychologist within the team. We found that psychology assessments informed care plans for providing care to patients with complex needs. Some of the nursing team have received some basic cognitive behaviour therapy (CBT) training which is supervised by the psychologist, who also leads on the clinical supervision for the staff group.

Until very recently there has been a designated pharmacist allocated to the ward. The pharmacy is now based at Woodland View in Irvine. Staff commented on some difficulty accessing pharmacy: The consultant on the ward and the SCN plan to put

their concerns in writing to the hospital managers regarding the need for a designated pharmacy for this service.

There was good attention paid to the physical healthcare of patients. The SCN advised that one of the nurses is both a registered mental health nurse and a general nurse who actively contributes to the provision of physical healthcare for all. Patients receive annual physical health checks, and there is additional monitoring in place for patients with other chronic healthcare conditions. We also saw evidence of referral to specialist services if required. All patients are regularly reviewed by dentist and podiatry. We discussed the patients' access to the National Screening programme. The SCN said that often the appointments for national screening services, would go to the patient's home address, which made it difficult for the service to ensure patients had access to the national screening services. We would suggest that the team works with the patient and where possible carer/family to try to overcome this.

There was evidence of carer/family's involvement. The relatives we met with on the day felt that they were involved in their relatives care as appropriate. They were very positive about the care and treatment their relatives were receiving on the ward. They also stated that the staff team were always welcoming and approachable. The service had also facilitated the use of wifi and Skype to ensure family contact for a patient.

The SCN told us of a recent initiative to improve their services. This involved a patient/carer/staff questionnaire seeking information on many aspects of treatment such as: care and compassion, maintaining relationships, person-centred care, information regarding legal aspects, enhancing carer involvement and the environment. The survey took place in October 2016 and it has generated recommendations and an action plan. The team are working from this action plan to implement change to improve their service. Following implementation they will review the outcomes and also plan to revisit the survey in 2018. We were shown a copy of this comprehensive report.

### **Recommendation 1:**

Hospital managers to ensure that all patients have access to the national screening programmes.

### **Use of mental health and incapacity legislation**

On the day we visited five of the patients were detained, we looked at all of the Mental Health Act (Care and Treatment) (Scotland) Act 2003 (MHA) paperwork, and no concerns were identified. We were pleased to find all consent to treatment certificates (T2) and certificate authorising treatment (T3) under the MHA were in order.

Adults with Incapacity (Scotland) Act 2000 (AWI), s47 consent to treatment authorisations were in order, along with accompanying care plans.

## **Activity and occupation**

Most of the activities on the ward are organised by the nursing staff, and are based on the patient's needs and strengths and where possible the patient's opinion. The activities are mostly provided on a one to one basis. Some of the sessions provided were CBT for low intensity anxiety management, lifestyle skills, and social and recreation trips. The staff also organise quizzes, bingo, karaoke, music and light exercise. The activities the patients participated in were recorded and held on a paper file. We would expect to see a person-centred activity care plan to support those activities.

The OT has input on a sessional basis, they are involved in functional assessment, assessment of risk, life skill development and discharge planning.

At present the patients are unable to use the therapeutic kitchen within the ward as there is a need for some adjustments to allow the room to be used safely. This facility is used by both OT and nurses to assess, develop and maintain life skills. There is another small room that the service use at present but staff comment that this space is small, has poor natural lighting and is not well ventilated.

### **Recommendation 2:**

Hospital managers should ensure that refurbishment is undertaken as soon as is practicable to make the kitchen accessible. Hospital managers should ensure that refurbishment work including amendments to the small visiting room is undertaken as soon as is practicable.

## **The physical environment**

The ward was clean, bright and well maintained to a high standard: using pictures lighting and items to personalise space which contributed to a pleasant atmosphere. The sitting areas were well furnished and comfortable. Bedrooms were personalised with photos and belongings and efforts have been made to make them as comfortable as possible. However it was very concerning that the ensuite toilets did not have doors, which means that that privacy is compromised if anyone entered the room whilst patients were in the toilet. We were told that when the units were built the ensuites were not meant to have doors but the areas are curtained to ensure some privacy. We are aware that some of the wards have removed the curtains due to ligature risks and that some ensuites have now had doors fitted, and there is a bid for this to happen to all ensuite rooms.

The main garden area was easily accessible, the door was open on the day we visited and some of the patients were sitting out enjoying the sunshine. The garden is enclosed and very pleasant, well stocked with plants and very well maintained. It is a useful facility for patients in the summer for both garden and leisure. The hospital grounds have several walking paths that are used frequently by patients.

Through the patient/carer/staff survey one of the action points identified was for the service to create a small visiting room for families. We discussed with the SCN the potential use of the small room next to a garden area that would be suitable. The room would require some refurbishment, but the position of this room within the ward offers both privacy and access to a small garden, this would be of benefit to both patients and families.

### **Recommendation 3:**

Hospital managers should arrange for doors to be fitted to the ensuite toilets as a matter of urgency to ensure privacy and dignity for patients.

### **Summary of recommendations**

1. Hospital managers to ensure that all patients have access to the national screening programmes.
2. Hospital managers should ensure that refurbishment is undertaken as soon as practicable regarding the therapeutic kitchen. Hospital managers should ensure that refurbishment work including amendments to the small visiting room is undertaken as soon as is practicable.
3. Hospital managers should arrange for doors to be fitted to the ensuite toilets as a matter of urgency to ensure privacy and dignity for patients.

### **Good practice**

The two areas listed below evidence the team are developing new approaches to care.

The staff team for Clonbeith have been nominated for the 'the team of the year' and a 'compassionate care award' (Ayrshire Achieve Awards (NHS)).

Although challenging to arrange, the SCN commented that they make a priority of having a staff training/development day. The staff have received training in appreciative enquiry. This is a strength based approach to development which looks at the individual's strengths and skills within the team, and it is then applied to developing the service. This approach is used by the team to assist with future planning for the service they deliver, and is evidenced through some of the creative and innovative work within this service.

### **Service response to recommendations**

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

**MIKE DIAMOND**  
**Executive Director (social work)**

## **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 MWC 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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