

Mental Welfare Commission for Scotland

Report on announced visit to: Lochranza Ward, Ailsa Hospital,
Dalmellington Road, Ayr KA6 6AB

Date of visit: 23 March 2017

Where we visited

Lochranza is a 14-bed long term rehabilitation ward for male and female adults on the Ailsa Hospital site. As part of the service redesign for inpatient rehabilitation services in NHS Ayrshire and Arran, several other rehabilitation wards that had been collocated at Ailsa Hospital were closed in early 2016; new rehabilitation wards were opened at Woodland View Hospital at that time. Those patients who were not assessed as appropriate for transfer to the new wards remained at Lochranza to continue receiving slow-stream rehabilitation.

As part of the continued redesign across inpatient and community services, Lochranza is currently marked for closure in March 2018. Therefore, there is currently a process of resettlement and re-provisioning for patients, leading up to the eventual closure of this unit. The relevant council social work services have been coordinating the assessment of each person's needs and their suitability for placement in social care services.

We last visited this service in February 2014 as part of a visit to all four rehabilitation wards (forensic and non-forensic) that were at Ailsa Hospital at that time. At that time, and of relevance to Lochranza, we were very positive about the enthusiasm of staff to continuously improve the services for patients in their ward. Patient independence was promoted and self-catering facilities were made available for patients. We made a recommendation for a review of resources to support physical health initiatives, particularly as staff were highly motivated to engage with patients on the ward regarding their physical health.

We visited on this occasion to see what input for patient physical health is provided. We wanted to give patients and carers an opportunity to raise any issues with us, particularly as we are aware of the intended ward closure and associated concerns about the future for patients. We also wanted to hear from patients and staff about any impact on Lochranza following the closure of all other rehabilitation services on the site.

We also looked at:

- Service user participation
- Rehabilitation activity
- Use of legislation
- Physical environment

Who we met with

We met with three patients and received the views of three other patients through an advocacy worker. We looked at the records of eight patients. We also met with the relatives of five patients.

We spoke with the ward manager, several members of nursing staff, the clinical nurse manager, and one of the consultant psychiatrists for the ward. We also met with an advocacy worker.

Commission visitors

Jamie Aarons, Social Work Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The nursing staff told us of the strong staff team they feel they have, which they believe contributes to the care and treatment received by patients. We were informed that in anticipation of the closure of other wards on site, Lochranza's staff team was increased and staff report feeling supported by each other. We were informed that Lochranza staff do not feel isolated on the Ailsa campus. They reported that they have a morning "huddle" with the older adult wards on site and any anticipated staff shortages are managed in advance.

Care plans are person-centred and detailed in terms of physical and mental health. Patients' rehabilitation plans include building from their strengths and abilities, taking into account patients' own goals and interests. All patients have a weekly planner; those we saw accurately reflected what had been done and what was planned for the coming week. It was clear that staff knew the patients well and their care and treatment was appropriate to the patients' current needs.

We were able to see regular reviews of care and treatment recorded in both the review paperwork and in the chronological notes. Families and patients are invited to attend multidisciplinary team meetings (MDTs). Following MDT meetings, patients are offered an 'emotional touchpoint', in which staff seek patient feedback on the MDT, with the intent of improving service delivery for individuals.

All relatives and patients with whom we spoke were anxious about the plans to re-provision the service and did not want the unit closed. They told us that patients concerned had a long history, some over decades, of community and hospital placements; we were told of several failed placements when individual needs were not met. They told us that Lochranza staff had been able to manage the complexity of

these needs and improve the quality of life for those individuals, while promoting independence. They were unclear of the rationale for potentially disrupting patient stability and questioned what has changed if these patients were not assessed as suitable for Woodland View – with the recognised potential for community discharge – a relatively short time ago (2016). Additionally, patients and relatives expressed concerns about the time it may take to find appropriate placements for those assessed as being able to move to a community resource; they feared that unsuitable placements would be commissioned hastily to meet the ward’s intended closure date. Relatives highlighted their desire for more information to be shared with them by social workers about community provision ideas and progress.

Staff confirmed that some current patients have had multiple failed discharges; some have fragile mental health. Staff reflected that while most patients currently present as stable and settled, this stability is due to the staff, routine, and familiarity of the ward. Nurses feel that they can intervene and deescalate situations swiftly because they know the patients so well and recognise early warning signs of anxiety or deterioration in mental health. We were informed that there is a low use of ‘as-required’ medication on Lochranza; staff attribute this to a combination of factors, including patient/staff relationships, therapeutic interventions used to good effect and the sensory room, which is used regularly to provide patients with a calm, quiet, and low stimulation environment.

It was evident from the chronological notes and from talking to nursing staff and relatives that the ward actively promotes and supports family involvement in patients’ lives and, where appropriate, in discussion of patients’ care and treatment. Relatives consistently and emphatically reported feeling welcomed and included in Lochranza.

When discussing access to independent advocacy, we were informed that there are different service-level agreements for the three different health and social care partnerships that have patients admitted to Lochranza. There are regular visits from the advocacy service covering patients from South Ayrshire, which includes the majority of patients. There is not regular input from the advocacy services from North or East Ayrshire, though referrals can be made if requested by patients or felt appropriate by staff. There is a monthly patient-led community meeting for patients to share any concerns or ideas to contribute to the running of the ward. In partnership with each of the three local authorities, the ward should promote equal opportunity for access to advocacy services for patients.

There is a high level of attention paid to the physical healthcare of patients. The ward employs a ‘health and well-being advisor’ who is a nurse with a focus on physical care and health improvement. She works on bespoke care plans for patients in relation to aspects of physical health like smoking cessation; weight management; and brief interventions related to substance or alcohol misuse. Patients receive annual physical health checks, in addition to “mini physical health checks” every four weeks. Patients’ views are sought prior to the health check. Patients are encouraged to contribute their

views on their general health, changes or concerns, medication, diet and level of activity. If patients require access to services regarding any physical health problems, we were informed that they are seen quickly. Additional monitoring is in place for patients with diabetes or other chronic health conditions.

Ward staff reported that 11 of 14 patients smoke, despite that staff are regularly encouraging them to stop and attempting to engage them in smoking cessation options.

Use of mental health and incapacity legislation

On the day of our visit, most patients were informal; they were not subject to the Mental Health Act (MHA). We were pleased to see evidence in MDT minutes that patients' detention status – both formal and informal – is regularly reviewed. Where patients are not consenting to remain in hospital or are not accepting elements of their care and treatment plan, consideration is given to the need for use of safeguards under the MHA.

We were pleased to find all consent to treatment forms (T2) and forms authorising treatment (T3) under the MHA. There is pharmacist input into the MDT meetings and the pharmacist audits T2 and T3 certificates. We did find one expired s47 incapacity certificate under the Adults with Incapacity Act (AWI). This was discussed with the ward manager on the day and an audit of all s47 certificates will be completed to ensure that they are in date and include relevant treatment plans.

There are good personal spending plans for those patients whose funds are managed under Part 4 of the AWI Act. We saw efforts to encourage spending on appropriate items and think of ways patients could benefit from their money.

With the intended closure of the ward and a transition of patients to community resources, ward staff are aware that for some patients other provisions of the AWI Act, including welfare guardianship, may be required. The clinical nurse manager confirmed that discussions have commenced with representative local authorities for patients who may require a welfare guardian but do not yet have one.

In reviewing the current recording system on the ward for patients subject to AWI measures, we recommended being more explicit when patients are subject to Part 4 of the AWI Act for finances; when they have a s47 certificate in place for physical healthcare; and when there is a proxy decision maker granted (welfare guardian or power of attorney). This will help to avoid confusion and ensure that welfare proxies are consulted at appropriate times. The ward manager agreed on the day of the visit to make the alterations recommended to their record-keeping, and the electronic recording system will also be used to document AWI status in a way that can be accessed by hospital and community-based staff.

Activity and occupation

Rehabilitation plans are person-centred and build on patient strengths and interests, with a view to enhancing independence to as great an extent as possible. The ward has a therapy kitchen, which is open to patients to make their own meals independently or with staff support. Self-catering and related tasks (shopping, budgeting, meal planning) form a part of many patients' activity care plans.

We were told that engagement in rehabilitation activity can be difficult for some patients who are distracted by their need for a cigarette. There have been occasions when patients have been found smoking in their bedrooms.

We were told about visits from a therapist, which are well-received by patients.

The physical environment

The ward has seven en-suite bedrooms and seven single rooms that share adjacent toilet and shower facilities; there is a maximum of two patients sharing any one toilet or shower.

We were pleased to see that the ward is clean, bright and maintained to a high standard; fresh flowers throughout the ward contributed to the pleasant atmosphere. The sitting rooms are comfortable and well furnished. Bedrooms are personalised with photos and belongings and efforts have been made to make them as homely as possible.

The garden area is pleasant and well maintained. It is a useful facility for patients in the summer for gardening and leisure. Several patients commented on the ease of access to the garden and we were told that a special area for roses within the garden has been created for patients to commemorate loved ones who have died. In addition to the ward garden, the hospital grounds have several walking paths that are used frequently by patients, during escorted and unescorted time off the ward.

As noted above, the sensory room, which includes soft furnishings, light tubes, and calming sensory equipment, is used regularly by patients who prefer this environment to deescalate or relax.

Good practice

The ward's monthly newsletter is well-received by patients and relatives. We were also impressed by the questionnaire sent to carers, which is used to help shape services.

We were impressed by the introduction of the health and well-being advisor role. We thought that the form for patients to complete in advance of the physical health check, which can also be used as a prompt sheet for staff to discuss with the patient, was

an effective means of engaging patients in their physical healthcare and identifies priorities set by them.

Summary of recommendations

No recommendations were made following this visit.

Service response to report

The Commission request an update on changes made to the ward's record-keeping in relation to patient AWI status within three months of the date of this report.

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

Alison Thomson

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 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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