Mental Welfare Commission for Scotland

Report on announced visit to:
Ayr Clinic, Arran, Bellisle and Low Green Wards, Dalmellington Road, Ayr, KA6 6PT

Date of visit: 3 October 2024

Where we visited

The Ayr Clinic is an independent hospital that offers mixed-sex, low secure care across three wards. The wards are Arran, which has 12 female beds; Belleisle which has 12 male beds; and Low Green, a 12-bedded, previously mixed-gender ward however, currently for males only. All wards provide care for patients with a primary diagnosis of mental illness, personality disorder and/or mild learning disabilities. All are subject to compulsory treatment provided under the Mental Health (Care and Treatment) (Scotland) Act, 2003 or the Criminal Procedures (Scotland) Act, 1995.

On the day of our visit, there were three vacant beds, however these were already booked for individuals being transferred from other hospitals.

We last visited Bellisle Ward in August 2023; Arran and Low Green were visited the previous year, in September 2022, both on announced visits. The recommendations for Low Green and Arran Wards included improving the recruitment of nursing and health care support staff, ensuring the gym areas were less cluttered and fit for purpose and expediting the planned refurbishment works. The visit in 2023 to Bellisle Ward made recommendations in relation to auditing nursing care plans, ensuring that care records were personalised, goal and outcome focussed and provided more detail regarding how individuals present throughout the day, with a final recommendation on the completion of relevant paperwork for individuals who had restrictions placed on them as specified persons.

The response we received from the service confirmed that there was an action plan that addressed these and in the case of staff recruitment, this was a challenge HSCPs are facing nationally.

On the day of this visit, we wanted to follow up on the previous recommendations and look at and hear about any national or local initiatives the wards had engaged in to improve individual care and the recovery journey.

Who we met with

We met with, and reviewed the care of 14 people, meeting 11 on the day in person. We also met spoke with two sets of relatives, one on the day and one after the visit.

We spoke with the ward managers for each ward, members of the senior management team and the consultant psychiatrist. We also met with the lead psychologist who was available to chat with us on the day.

Commission visitors

Margo Fyfe, senior manager

Paul Macquire, nursing officer

Justin McNichol, social work officer

Mary Hattie, nursing officer

Mary Leroy, nursing officer

Lee Whittiker, student nurse

What people told us and what we found

Overall, individuals on the wards were positive about the staff and about the care and treatment they had received. One individual commented “staff are great” while another said, “the nurses have helped me get better.”

More specifically we heard “he is the best doctor we have had here; he was great when my physical heath was poor.” Another individual mentioned the psychologist, saying “She is really experienced. She is easy to talk to and I have a lot of faith in her abilities.” Another individual commented on the psychologist “we work well together; we have known each other for a long time.” An individual mentioned activities on the ward in a positive way and told us that they were happy that these are renewed on a regular basis.

We did hear less positive comments from some individuals. In Arran Ward, several people commented on the high number of bank and agency staff used, particularly at night. More specifically, we heard that working with staff whose first language was not English could sometimes be difficult, especially during times of distress and when it related to past traumas, there was an inability to connect with the staff.

Recommendation 1:
Managers should consider the ability of bank or agency staff to communicate in a therapeutic way with individuals who have suffered trauma. Staff should be able to recognise sensitivities around times of stress and distress.

We heard that there continues to be a challenge in recruiting qualified nurses and health care support workers. Currently, the unit has 6.8 whole time equivalent nursing vacancies after six nursing posts were successfully filled including four NQNs and two more experienced nurses. We heard that a core group of bank and agency staff fill shifts to ensure the wards are staffed appropriately and with as much consistency as possible. Senior managers recognised that this was an issue and continue to do all they can to recruit staff. We understand this is an issue affecting nursing nationally but would encourage the clinic to continue attempts to recruit qualified nursing staff.

Care, treatment, support, and participation

Overall, we found evidence of positive care planning and the care records we reviewed had a clear multi-disciplinary approach. There was evidence that care planning reviews were completed at regular intervals.

Care plans were holistic, person-centred and included the views and beliefs of the individuals; this was positive to see and an improvement on the last visit where a recommendation was made on ensuring care records detailed individual daily activities and clinical presentations.

Multidisciplinary team (MDT) notes were clearly documented and easy to follow, with each professional who had attended the MDT noted. We found that these records included the views of the individual and carers, where appropriate.

Care records
Ayr Clinic had their own electronic patient records system. This was simple to navigate and accessible. All relevant information was easy to find and included pictures of each individual and there was a life history in the care record.

Evidence of one-to-one interventions between staff and individuals was recorded in the care records. Care plans covered not just mental health, but also physical health care was considered, which included monitoring of the use of high dose anti-psychotic medication and general health checks.

Care plan reviews were linked to the care plan and described progress, if achieved, with the treatment that had been delivered.

Risk assessments were also available, and of a high standard; these were detailed, specific to individual risks/needs and reviewed regularly.

Documentation on the input of psychology and occupational therapy (OT) documentation was also available. We were pleased to see a positive focus on the work of these disciplines and that the provision of psychological and occupational work in the clinic was recognised and valued by the individuals on the ward.

Multidisciplinary team (MDT)
The MDT consisted of two consultant psychiatrists who provided cover for the three wards, an in-house psychology team, nurses, care support workers and OT staff. The unit used a locum dietitian who is currently on maternity leave. The MDT meet with individuals and carers/relatives on a regular basis. Regular access to medical staff was helpful and comments from individuals recognised the positive relationships they had with the whole MDT. A representative from Circles advocacy was available on the day to discuss their input to the service.

We heard from one individual that there was a lack of access to dietetics which would have been beneficial for their care; this was addressed with staff on the day and will be resolved when the locum dietitian is available again.

Use of mental health and incapacity legislation

22 individuals were being treated under a compulsory treatment order of the Mental Health (Care and treatment) (Scotland) Act, 2003 (the Mental Health Act). 13 individuals were being treated under the Criminal Procedure (Scotland) Act,1995 (Criminal Procedure Act).

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. We found 22 individuals had medications recorded in T2 certificates and 21 authorised with a T3. One patient was prescribed no psychotropic medications. All of the files we reviewed where T2/T3s were in place corresponded with the medications prescribed.

Any person 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 documentation to be in place and where there was a named person, they were included in decisions made and this was clearly documented in the care records. Those that we spoke with confirmed they had been offered the opportunity to identify a named person.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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.

The section 47 certificates that we reviewed were, in the main, appropriately completed. We found one incomplete s47 certificate and no record relating to the welfare guardianship powers. Another record we reviewed had welfare guardianship papers without evidence of who the guardian was.

Recommendation 2:
Managers should audit AWI Act documentation including authority to treat forms (s47) and welfare guardianship orders to ensure these are fully completed and available to the staff.

Rights and restrictions

Ayr Clinic is a low secure hospital. When you enter the building there is a reception area which allows you to access the ward areas, upstairs and outside space. Entrance/exit doors to the wards were locked, this would be expected due to the security level of the hospital.

Posters highlighting individuals' rights were available on the ward notice boards; these provided information about advance statements, named persons and accessing advice from Mental Welfare Commission. Those that we spoke with on the day of the visit advised us that they were aware of their legal status and their

right of appeal. They also were aware of how to access advocacy and seek legal representation.

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. Where restrictions were placed on individuals who were made specified persons, we found the reasoned opinions from the consultant psychiatrists recorded in the care record. Individuals that we spoke with had a reasonable understanding of any restrictions that were in place and the reasons for this.

We found all but two individuals had been made specified persons and had restrictions for safety and security. A further nine had restrictions placed on their use of the telephone.

On the day of the visit, one individual was being cared for with an enhanced level of observation. We noted that there was therapeutic care and continuous interventions being provided throughout the day.

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 several advance statements on file and noted that there had been an override of one of these. The consultant was able to produce the override paperwork on the day and update us on the decision and discussion with the person.

Activity and occupation

Individuals and staff were positive about the activities and occupation on the wards. These were varied, plentiful, person-centred and linked to individual care plans.

We heard about individuals going swimming and regular walking groups. Individuals were also encouraged to engage in activities that supported their recovery and progress to a community setting. A program for activities was available for us to see and we were pleased to hear that a forum had been set up for individuals to discuss their views with peers and have these included in decisions in the wards.

The OT department had also made a newsletter for carers/relative that would keep them informed of what was going on in the clinic.

The physical environment

A previous recommendation noted that the gyms were cluttered and not fit for use. This issue had been resolved and the gyms were clear of clutter and equipment was safe for individuals to use.

The layout of the wards consists of 12 single rooms; all were en-suite. There was a lounge area and a separate dining area. Bedrooms were spacious and had storage and a safe for individuals to use. We were told that there were regular monthly walk rounds with managers and estate staff to ensure that any outstanding repairs were quickly identified and remedied.

The environment was clean, and we were able to see where efforts had been made to soften the public rooms. There was a games room and gym area in the wards; staff told us this was a popular area in the evenings and was well used. There was also a laundry and therapy kitchen which allowed individuals to develop and maintain skills in cooking and laundry care. Repairs to the tumble drier had been completed since our previous visit.

There were quiet areas and music rooms that could be used for visits, as well as a larger meeting room that was situated off the wards and used for visits involving children. The decor looked tired in places, but we noted some improvements from previous visits with no major works required.

Each ward had a small garden area which was accessible from the dining area, however access to this was limited and dependent on adequate staffing.

Any other comments

We were particularly pleased to hear of the positive work being done by psychology and the varied activities being supported by OT and nursing staff. We were impressed with the dedication of the senior charge nurses to their role and the leadership skills shown with their staff group.

We noted that on the day of our visit to Belleisle Ward that the SCN spent a significant amount of their time answering calls that were coming into the office. We suggested that if this was a regular occurrence, then consideration of a ward admin worker role could be put in place and that this could better support the SCN to allow them to complete all other crucial aspects of their leadership role.

Summary of recommendations

Recommendation 1:
Managers should consider the ability of bank or agency staff to communicate in a therapeutic way with individuals who have suffered trauma. Staff should be able to recognise sensitivities around times of stress and distress.

Recommendation 2:
Managers should audit AWI Act documentation including authority to treat forms (s47) and welfare guardianship orders to ensure these are fully completed and available to the staff.

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.

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 carer's, 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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