Mental Welfare Commission for Scotland

Report on announced visit to:
Wards 9, 10, and 11, Woodland View Hospital, Kilwinning Road, Irvine, KA12 8SS

Date of visit: 25 September 2024

Where we visited

Wards 9, 10, and 11 in Woodland View are 20-bedded, mixed-sex adult acute admission mental health wards. The wards are situated in the grounds of Ayrshire Central Hospital in Irvine and serve East, South and North Ayrshire areas respectively. The wards provide assessment and treatment for adults who have a diagnosis of acute mental illness and/or behavioural difficulties. On the day of our visit, the wards were mostly full with only two available beds across the adult admissions wards.

We last visited all three wards in September 2023 as an announced visit and made two recommendations. These included ensuring adequate medical cover was in place for the wards during times of absence or vacancies and ensuring authority to treat documentation was audited appropriately, in accordance with legal requirements.

On the day of this visit, we wanted to follow up on these recommendations and hear about any developments or changes in the wards. We were also keen to meet individuals, carers/ relatives, advocacy, and all staff groups who are involved in the delivery of care in the wards.

We were keen to hear of new developments and initiatives being introduced to the wards. Ward 10 was a pilot site for improving observation practice (IOP), supported by the Scottish Patient Safety Program (SPSP) and this work has been progressed into the other wards. There was an initiative being developed by junior medical staff who had plans to audit and improve individuals use of their named person as a legal safeguard in their care; this group of staff, alongside their multidisciplinary team colleagues were also planning to review access to advocacy services in the three wards. The initiative had been developed to ensure all who accessed care and treatment in the wards were aware of their right to access advocacy and to reduce barriers in doing so.

Who we met with

We met with, and reviewed the care of 14 individuals, 11 of whom we met with in person and a further three we reviewed the care notes of. We also met with two sets of relatives on the day and spoke with another carer on the telephone after the visit.

We spoke with a hospital director, lead nurse, two of the three senior charge nurses (SCNs), two charge nurses and two medical staff at senior psychiatric trainee level. We also spoke with advocacy and occupational therapy on the day. Unfortunately, the service manager and general manager were not available.

Commission visitors

Paul Macquire, nursing officer

Justin McNicoll, social work officer

Anne Craig, social work officer

Kathleen Taylor, engagement and participation manager

Kirsty Macleod, engagement and participation officer (carer lived experience)

What people told us and what we found

Those that we spoke with on the day were overwhelmingly positive about the care they received, about the environment and the staff who were providing care. We heard that the staff were “supportive, kind and helpful.” We heard comments that the nursing staff “support me to get better.” We heard that nurses offer “lots of one-to-ones.” Individuals commented that nurses and medical staff were “accessible.”

There were a number of individuals who were keen to discuss their care and treatment with Commission visitors. They provided us with specific details on aspects of their admission, their symptomology, their opinions about individual staff or their views on the service. Where and individual raised concerns that may have required mediation or a response by the service to the concerns and complaints they raised with Commission visitors, they were signposted to the appropriate staff and service. Those that we spoke with agreed to liaise with their responsible medical officer, the care team or their advocate, where appropriate.

There were some mixed comments regarding the activities that were available. Some individuals enjoyed the walking groups and felt activities were plentiful and well supported by occupational therapy (OT) input. However, other individuals described feeling “bored” at times when they were on the ward and complained of “just spending time in my room watching Netflix”. Despite this comment, the individual made it clear that they were aware of the available activities on the ward. These comments contrasted with what we witnessed and what we were told was on offer regarding the groups and activities on the wards.

On the wards, there was evidence of planned group activities that were varied, therapeutic, and constructive. We did consider that what was on offer could be better communicated to people in a way that encouraged better participation across the service.

Mental Welfare Commission visitors witnessed individuals being cared for in a compassionate and person-centred way. We noted an acutely unwell individual being nursed using continuous intervention, where the approach used by the staff was helping to reduce the individual’s level of agitation throughout the day.

Individuals commented positively on the physical environment and were generally positive about the food, although described it as “a little repetitive” at times.

On Ward 11, concerns were raised with us by an individual and their relative/ carer in relation to their care and treatment. As this was a complaint where we provided advice, we escalated this to staff on the day of the visit; we will follow this up post-visit.

Overall, we observed considerate and committed staff who were positive about working in Woodland View. Staff described positive opportunities for continued professional development (CPD) and that the wards provided a supportive workplace with regular clinical supervision. We noted effective nursing leadership on all three wards.

Care, treatment, support, and participation

Care Planning

Commission visitors reviewed care planning on the electronic system, Care Partner. Overall, the quality of care planning was person-centred and included evidence of individual involvement.

Holistic actions were noted in care plans that evidenced individualised goals. The named nurse system appeared to be working well, with individuals having a good understanding of the actions of the care team who were supporting them through their journey and they were aware of who to go to during times of crisis. The quality of care planning was consistent across the three wards, however care plan reviews were not of the same standard. We noted inconsistencies in how care plans were reviewed and it was the same for the documentation as to how an individual was progressing through their recovery. The inconsistent nature of how care plans were reviewed meant that it is not always clear how someone had made progress in working towards their goals.

We also noted that some care pans had not been reviewed and there were others where reviews were out of date. We had feedback from our engagement and participation team members that in some instances, carers’ views could be better represented in care plans. This was discussed with SCNs on the day at the feedback session.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Managers should ensure that care plans are audited to provide assurance of a high standard and care plan reviews are clearly documented, timeously and meaningful in relation to reviewing individuals progress in treatment.

Care records
All care records were held on the Care Partner system. As mentioned in other visits to this hospital, this is a comprehensive and accessible system. It makes all relevant information easy to find and presents individuals' histories in a way where gaining an understanding of an individual is possible, even with our visits that take place on one day.

On the day, staff in the wards were helpful in supporting the Commission team to access the system and supported navigation for any visitors who had not used it before.

The system held continuation notes, care plans and MDT notes that were up to date and accessible. Health and social care notes were available, as was legal documentation and other correspondence associated with each individual.

Daily care records and continuation notes were somewhat more inconsistent at times. Commission visitors noted that some of the nursing documentation provided good examples of the care provided on a daily basis, with structured one-to-one interventions with individuals. However, there were other care records that lacked evidence that one-to-one interventions were taking place. This was discussed with SCNs and again at end-of-day feedback session.

In most cases, the evidence of nursing contact with individuals was positive although the language used when describing contact in the one-to-one sessions differed across the wards and even from nurse to nurse. This created a challenge when reviewing the contact in the records of individuals. Overall, there was evidence of effective and therapeutic nursing practice that had promoted person-centred and recovery-based care as was observed by the Commission visitors.

The NHS Ayrshire and Arran risk framework was set out in each individual care record. This was a robust document that contained vital clinical information on the individual's risk factors and how they link to the care they were receiving. These were fully completed and included an individual's views as well as the multidisciplinary team's (MDTs) clinical opinion. This information formed effective and clear risk management plans that were consistent across all three wards.

Care notes evidenced occupational therapy (OT) involvement, where individuals had access to this. OTs utilised Woodland View's 'Beehive' area, the atrium, and the grounds for walking groups. The Beehive area is a space close to the wards in Woodland View. It offers individuals the opportunity to take part in various

occupational and recreational activities that were recovery focused; activities such as playing pool, table tennis, reading and socialising with peers were available. The area provided an enjoyable alternative area for individuals away from the ward environment.

Multidisciplinary team (MDT)
The multidisciplinary team for the three wards included consultant psychiatry, junior medical staff, OTs, psychology and other specialist disciplines when required.

Evidence of MDT meetings were clear and well documented, however, our engagement and participation officers found that carer involvement could have been better defined in records. Documentation on the carer being invited to attend, and a record of whether they had/had not would have been helpful. A description of how carers were included in an individual's care would highlight how the triangle of care was achieved.

Recommendation 2:
Managers should ensure that carers views are included at all phases of the individual's journey as much as is possible. An audit of triangle of care information may help to provide a baseline and structure any improvement work in this area moving forward.

Records of MDT meetings were detailed and structured in a way that identified where an individual was in their journey, as well as covering all aspects of their care including medication, observations, and legal status. Meetings took place on a regular basis, and we heard that the medical team were accessible out with these times for individuals or relatives who required an update.

Commission visitors noted that there were fewer opportunities for individuals to have contact with advocacy and social work while they were on the wards, and specifically for those individuals who were being given care and treatment while under mental health and capacity legislation, this is something we would have hoped to see more of.

MDT notes provided evidence of discharge planning and in some cases, we were pleased to note that this had taken place at an early stage. This positive approach provided structure, engagement and collaborative working, with a recovery focus to inpatient care.

Use of mental health and incapacity legislation

On the day of the visit, there were 30 people across the three wards who were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

Individuals that we met with, and who were detained under the Mental Health Act had a reasonable understanding of their rights and if applicable, any restrictions they were under. We heard from several individuals that they would liked more of an opportunity to speak with advocacy. On the day of our visit, there was an advocacy worker in the ward and we were advised that advocacy cover was available across all three areas, although this was quite stretched.

We found all Mental Health Act paperwork to be in order and available for the Commission staff to review. Those individuals that we spoke with who were being treated informally understood their rights and no one described feeling restricted.

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 found all T2 and T3 forms in order and dated correctly. Any medication prescribed under T2/T3 authorisation correctly corresponded with what was prescribed and therefore no medications were noted to be prescribed or administered without legal authority.

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 an individual had nominated a named person, we did not find the named person documented in the records that we reviewed. However, when the Commission staff met with two psychiatry trainees, they discussed that this has been recognised in the wards as being an issue. The trainees described how they were planning to encourage detained patients to identify and use the named person scheme; they had already completed an audit that has identified that very few individuals use this legal safeguard. We noted that we would be interested to hear how this planned work progresses and suggested using the guidance available from the Commission's website.

For those people that were under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), we found that some wards had welfare guardianships and power of attorney documentation stored on the system. However, we found that in Ward 9 there were individuals who were under welfare and financial guardianship orders, but the legal documents were not available for us to review on the day. There was also some confusion with nursing staff who did not appear to understand the difference between local authority welfare guardianship and power of attorney (POA). During feedback we advised there may be a need for a training needs analysis and further training in this area.

Recommendation 3:
Managers should ensure that all welfare guardianship or POA documentation is available on the ward to staff treating individuals who are subject to these pieces of legislation.

Recommendation 4:
Managers should ensure that nursing staff have a working knowledge of welfare guardianship orders and POA to ensure the rights of any individual subject to these powers are being cared for with these powers in mind, whilst in hospital.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

We found that some of the section 47 documentation was out of date, and due to this, treatment that had been given was not legally authorised. We raised this at the feedback session and advised that this be resolved as soon as possible. On our visit to the wards in 2023, we had made the same recommendation about auditing the authority to treat documentation, and again found there to be an issue, so we have restated this recommendation.

Recommendation 5:
Managers must ensure where an individual lacks capacity and requires medical treatment under section 47 of the AWI Act that authority to treat documentation is completed fully and reviewed timeously.

Rights and restrictions

We noted that all access doors to the wards were locked, although entering and exiting the wards was supported by staff; we found no evidence of de-facto detention and individuals could come and go freely, where appropriate.

There was evidence of appropriate signage for individuals and carers. Rooms were available so that private visits could take place. We spoke to an individual and their carer who told us they were not allowed to have a visit in the individual's room; this was raised the SCN on the day of our visit and thereafter addressed.

Commission posters were evident on the walls in some areas, as well as information on accessing advocacy and legal support. However, we noted this was not consistent across all three wards.

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 specified person restrictions were in place under the Mental Health Act, we found that all appropriate paperwork was in order, including evidence of a reasoned opinion by the responsible medical officer. We noted that where an individual was not in agreement with being made a specified person, they had been informed, in writing, of the reasons for the measures and were aware of their right of appeal.

When we are reviewing individual 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. These are 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 did not find any advanced statements in the files reviewed. There was evidence that advanced statements were being promoted, with posters on the wards and as discussed earlier, with named persons. This may be an area that the wards consider further activities in to promote the uptake of advanced statements as a legal safeguard for individuals detained under the act.

The Commission has developed *Rights in Mind.*[2] 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

We heard from several individuals about the lack of activity in the wards. We were not able to establish if they were unaware of what activities were available, or if they had opted not to get involved in what was offered or if they preferred to remain in their room.

Individuals had their own ensuite rooms that were large and homely. They had access to the internet, and for some, they preferred to spend their time this way rather than joining groups or taking part in other therapeutic activities. Commission visitors noted that the promotion of groups and activities could have been more consistent done across the wards, although there was evidence of planned group work throughout in the morning, during the day and into the evening in one ward.

At the feedback session after our visit, we advised that when individuals are offered activities or groups, that this is recorded in their records and, it should be noted whether or not they participated.

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

The physical environment

Each of the three wards consists of 20 ensuite bedrooms. These were surrounded by a well-maintained garden area that was visible through large glass panels which provide natural light into the ward. The outside space, both the enclosed part in the ward and across the hospital site is well maintained; individuals who were subject to restrictions could continue to safely access outside space.

The nurse's station/office was centrally located and close to the dining area. The building continues to feel fresh, with a high standard of décor and furniture. Overall, the wards had a pleasant ambiance, creating a relaxed atmosphere.

Summary of recommendations

Recommendation 1:
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Recommendation 2:
Managers should ensure that carers views are included at all phases of the individual's journey as much as is possible. An audit of triangle of care information may help to provide a baseline and structure any improvement work in this area moving forward.

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Recommendation 5:
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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 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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