Mental Welfare Commission for Scotland

Report on announced visit to:
Woodland View, Ward 8, Intensive Psychiatric Care Unit (IPCU), Kilwinning Road, Irvine, KA12 8RR

Date of visit: 6 March 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

Ward 8 is the Intensive Psychiatric Care Unit (IPCU), an eight-bedded purpose build facility based in Woodland View Hospital.

An IPCU provides intensive treatment and interventions to individuals who present an increased level of clinical risk and require an enhanced level of observation. IPCUs generally have a higher ratio of staff to patients and a locked door policy. It is expected that staff working in IPCUs are competent, skilled, and experienced in caring for acutely ill and often distressed patients.

There were six individuals in the ward on the day of our visit, with one individual in the process of being transferred to another unit.

We last visited this service in December 2023 on an unannounced visit and made recommendations on reviewing the access to psychology and occupational therapy for individuals in the ward. The response we received from the service was that it agreed that it would be beneficial to review this resource.

On the day of this visit, we wanted to follow up on the previous recommendations and were pleased to hear that the ward now has an allocated resource for occupational therapy and working towards a permanent solution for dedicated psychology input. We were also pleased to hear that there is ongoing working to review the seclusion policy and to ensure that individuals receiving increased levels of observation do so with therapeutic, continuous intervention principles in mind.

Who we met with

We met with and reviewed the care of four people. We met with one relative who was visiting at the same time as the Commission. We spoke with the senior charge nurse (SCN), the lead nurse, and the general manager. We also met with the occupational therapist and two other members of the nursing team.

Commission visitors

Paul Macquire, nursing officer

Justin McNichol, senior manager/social work officer

What people told us and what we found

On the day of our visit, we observed that individuals in the ward had complex clinical needs. Some were so acutely unwell that it was not possible to have any meaningful conversation with them about their care and treatment. However, we were able to observe that those individuals appeared comfortable and at ease in the environment.

The individuals we were able to speak with reported that there was good support from staff in the ward and said the nurses were helpful and approachable. Some reported feeling that they did not agree with being detained in the IPCU but agreed that they have been involved in decisions about their care. They told us that they were aware of their right to appeal their detention. On reviewing their notes, we found their views and wishes were considered in their care plans and at the review meetings. Although they advised us that they were unaware of advocacy, we saw evidence this is promoted in the ward, and it was recorded in notes that this had been offered. Advocacy services are available from the three health and social care partnerships (HSCPs) within Ayrshire and Arran.

During our time on the ward, we saw staff interacting and communicating with individuals in a positive and supportive manner. Individuals who we noted to be acutely distressed by symptoms of mental illness and visitors received a compassionate and measured response from staff. Staff that we spoke with knew the people in the ward extremely well. Conversations with staff were positive and nursing staff described being well supported by senior staff and were receiving clinical supervision; we found that for staff in the IPCU environment, reflective practice was actively promoted.

As found in previous visits, Ward 8 benefits from good leadership and has developed clear processes that has enabled a consistent and structured nursing process; this is especially important in an environment that cares for the most acutely unwell individuals. The mix of individuals, with a variety of extremely complex needs can make this a challenging place to nurse, but we found a calm, therapeutic and compassionate environment that aimed to support recovery.

Care, treatment, support, and participation

Care records

The service has a well-established electronic patient records system. Care Partner is intuitive, simple to navigate, and it allowed the Commission visitors to access care records with ease. The individual's journey through the service was well evidenced in each case that we reviewed.

During our visit, we found detailed person-centred care plans that evidenced inclusion and were pleased to find that individual discussions informed some of the content and review of these plans. It was well documented where the person wished

to be involved with their plan of care or was unable to engage with the care planning process.

We also found a comprehensive level of information contained in one-to-one discussions with the named nurse. Nursing care plans were regularly updated; in the individual files we reviewed, we saw that these reviews were thoughtful, meaningful, and detailed the progress and changes in care. The individuals on the ward have their care and progress managed using the Positive Behavioural Support (PBS) plans and for some, the Care Programme Approach (CPA).

Risk assessment formed an essential component of all care plans. On reviewing the individuals' files, we found evidence of detailed assessment, supported by risk assessment and risk management plans. Risk management plans were reviewed regularly throughout the person's journey. We noted that the risk assessments were up to date, dynamic, and regularly reviewed.

Multidisciplinary team (MDT)

We saw in the electronic notes recordings of regular, weekly multidisciplinary team meetings (MDT) that included all of the relevant professionals. The MDT consisted of a core team involving nursing, psychiatry and pharmacy, with other disciplines such as psychology, occupational therapy, dietetics, physiotherapy, social work and speech and language therapy available and attending as required.

The MDT meeting records were well-documented, and recorded who attended each meeting, as well as containing a concise summary, with clearly recorded outcomes and actions. Individuals were invited to attend. On the day of our visit, we gave feedback that staff should make sure that named persons, advocacy or family/carers are invited as this is an important aspect to ensure the triangle of care is achieved.

Use of mental health and incapacity legislation

On the day of our visit, all six individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act).

Most of the individuals we met with during our visit had a good understanding of their detained status, where they were subject to detention under the Mental Health Act or the Criminal Procedure Act. All documentation relating to the Mental Health Act, the Criminal Procedure Act, and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment were in place and were up to date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, 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 and all corresponded to the medication prescribed on electronic system HEPMA. We found that all T3s had been completed by the RMO to record non-consent; they were available to view and up to date.

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 a patient had nominated a named person, we found copies of this in the care record.

We found copies of welfare guardianship orders under the AWI Act available in the files of those individuals who were subject to this legislation.

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.

During the visit we saw evidence of capacity assessments, appropriate use of the AWI Act, guardianship documentation and section 47 certificates that authorised medical treatment for individuals who lacked capacity. Section 47 treatment plans were in place to outline specific treatments authorised under this part of the AWI Act.

The Commission is working in partnership with NHS Education for Scotland to develop learning resources for the workforce to support and promote people's rights in the application of the AWI Act. Learning resources can be accessed at the Commission's website[1].

Rights and restrictions

Ward 8 continues to operate a locked door, commensurate with the level of risk identified with the patient group.

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 these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed. There were four of

[1] AWI Act learning resources: https://www.mwcscot.org.uk/law-and-rights/adults-incapacity-act

the six patients in the ward who were subject to specified person regulations. From the records we reviewed, we found the restrictions had been legally authorised.

It was difficult to locate the recording of the reasoned opinion for these restrictions, although we were pleased to hear that the ongoing work to develop a standard operating procedure for the use of sections 281 to 286 is progressing and we will be interested to discuss this at our next visit.

Although currently not an issue, we were concerned to hear that delayed discharges and inappropriate placement in the IPCU could, at times, impact on an individual's progress in their recovery. However, we were advised that due to clinical pressures within acute areas, there have been occasions where a patient was delayed in transferring out of IPCU. Where risk assessment and clinical presentation has allowed, the team have worked in a person-centred way and supported individuals to be discharged from IPCU to the community.

Senior staff agreed to continue to liaise with the Commission should these challenges impact individuals' journeys through the IPCU.

Commission visitors could see from records we reviewed that individuals who could be considered as having their discharge delayed are included on a dynamic support register and there have been concentrated efforts to find a positive, person-centred solution. An individual who has been considered to have been placed inappropriately for some time was reviewed by Commission visitors and assurances were given that the MDT continues to highlight, escalate, and document efforts to progress the person's transfer to a more appropriate setting.

Documentation clearly highlighted the efforts of the HSCP leads to meet with colleagues out with Ayrshire and Arran, in relation to finding an environment to meet the individual's needs; the Commission are keen to be kept informed of how this person's discharge progresses.

Activity and occupation

During our last visit to the ward, we made a recommendation around individuals' access to activities and occupation. The inclusion of an occupational therapy (OT) resource to the ward has helped this and we could see the evidence of the OT's involvement in care planning and how this promoted recovery with those who were acutely unwell in the ward.

On the day of the visit, we witnessed staff and individuals engaging in various activities. We were pleased to see that staff had time to play table tennis and board games with individuals; these therapeutic interactions had a settling and calming effect on those individuals who were experiencing stress and distress.

The physical environment

The physical environment in the ward is of a high standard. It is modern, bright, clean, and spacious. All bedrooms are en-suite and are purpose-built; individuals can come and go from their rooms as they wish.

The large open plan dining room/sitting room is comfortable and pleasantly furnished, offering immediate access to the secure courtyard. There are also smaller sitting rooms that provide people with a choice of where to sit. This space is of value for those who may prefer a smaller, and quieter space.

The ward has two outdoor spaces, one of which is landscaped with plants and shrubs. There is also a tarmacked sports area. We noted that these outdoor spaces were appreciated and well-used by individuals.

Any other comments

Overall, this was a positive visit with the Commission making no formal recommendations. This service benefits from positive, experienced, and dedicated leadership. Person-centred care is prioritised, and previous recommendations have been acted on to for the benefit of the vulnerable individuals who require a high level of support, care and treatment.

As discussed, there are individuals who do not require care and treatment in an IPCU setting and others who have been discharged from this service to the community. However, as a result of the professionalism, positive MDT approach and inclusion of individuals' views, individuals continue to receive care which is not detrimental to their recovery. There were assurances that ward staff and HSCP leads are working to find solutions to any individuals who do not require intensive psychiatric care.

Service response to recommendations

While the Commission will not respond as there are no recommendations, 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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