Mental Welfare Commission for Scotland

Report on announced visit to:
Woodland View, Ward 3 and 4, Kilwinning Road, Irvine, KA12 8RR

Date of visit: 31 July 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 3 is a 15-bedded, acute admission and assessment ward for adults aged 65 and over who are experiencing a decrease in mental functioning caused by a known physical or biological problem in the brain, such as dementia.

Ward 4 is a 15-bedded, admission and assessment ward that provides therapeutic nursing care for adults over 65 living with a diagnosis of functional mental illness such as schizophrenia, bipolar disorder or anxiety disorders.

On the day of our visit, both wards were full and Ward 4 had a waiting list for those who required admission.

We last visited these services in April and May 2023 as announced visits and made recommendations on employing a patient activity co-ordinator and reviewing occupational therapy input. The response we received from the services advised that they had applied for funding for an occupational therapist to work across Wards 3 and 4 and that provision of activity in the wards is provided in various ways, such as with a new interactive system that been purchased and was being used daily across both wards.

Who we met with

We met with, and reviewed the care of seven people, six who we met with in person and one further individual who we reviewed the care notes for. We also met with and spoke with two relatives.

We spoke with the senior charge nurse (SCN), deputy charge nurse, discharge co-ordinator (Ward 4), psychologists, the occupational therapy manager and their team and a student nurse.

Commission visitors

Anne Craig, social work officer

Justin McNicholl, social work officer

Mary Hattie, nursing officer

Audrey Graham, social work officer

What people told us and what we found

In Ward 3 and Ward 4, most people we spoke with were happy with their care and treatment and felt involved in decisions. People commented that “staff are great, some of them really go above and beyond” and “when I can’t sleep they will play music for me or sit with me if I am anxious; they never get annoyed”. We also heard “I can’t fault my care; they have done so much for me”. We were told that “staff treat me well” and that they were “fantastic” and that “they put up with a lot”.

We heard from one person that the food was “variable” with “improvements in the quality” being necessary, the staff were “just people” and treated them “reasonably well”. Someone else told us that staff were “very helpful and did everything they could to make them comfortable”. For some individuals, due to cognitive impairment, they were unable to provide any comment.

Relatives we spoke with said that the nursing teams were “fantastic” and one family commented about the staff in Ward 4 saying that they knew their loved one was “safe, cared for and they didn’t worry about them”; the staff in Ward 4 “just got him”. They also said that they “never had any concerns about the staff” and the staff would also ask them “how are you?”, showing care for the whole family but when their loved one was in Ward 3, they felt they were a “nuisance”.

A relative whose loved one had been in Ward 3 called after the visit to discuss their experiences, with reference to lack of communication from the ward staff and referred to it as “terrible”, although they acknowledged that the staff were very caring. They also said that when their relative was admitted to hospital, they had five sets of clothing, but now, there was hardly any left, despite home washing arrangements. They were very complimentary of the medical team who were open and honest with the family. Further information on the content of this call was provided to the service manager by the Commission visitors after the visit had been completed.

We also spoke with a student nurse who wanted us to know of the learning opportunities they had received in Ward 4. They heard that these were outstanding and that they felt a valued member of the team. They wanted us to know how well the staff team worked together for the good of the people on the ward and their relatives.

Care, treatment, support, and participation

Care records

Electronic records were stored on Care Partner; there was no information held in paper files. Care Partner was easy to use and the information was readily accessible. The records that had most recently been uploaded to the system were immediately available.

In Ward 4, the care plans were holistic, person-centred, detailed and reflected the goals and objectives for individuals. When care plans had been reviewed and/or updated, it was not immediately obvious, and we sought support to view these. We found that the care plans in Ward 3 had no reviews and could have been improved. Where new care plans were available, they could have been more meaningful.

Recommendation 1:
Managers responsible for Ward 3 should undertake regular audits of the care plans to ensure these are person-centred and updated to accurately reflect an individual's current needs and planned interventions.

Of the care plans that we reviewed, where there were concerns about physical health, these were detailed and included actions to be taken when a person became physically unwell.

In Ward 4, risk assessments were detailed, up to date and reflected a person-centred approach; the care records and multidisciplinary discussions were informed by the risk assessments. NHS Ayrshire and Arran use the Ayrshire Risk Assessment Framework (ARAF) although in Ward 3, we were concerned that risk assessments were limited, there were no risk management plans and where there was information, it was in a copy/paste format.

Recommendation 2:
Managers responsible for Ward 3 should ensure that risk assessments and risk management plans are audited and reviewed on a regular basis.

We asked about anyone whose discharge from hospital may be delayed. In Ward 4 there are two people who were considered as being delayed discharges. Ward 4 had its own discharge facilitator who provided support from pre-admission to post discharge. Support was given to people when they were well with consideration being given to what a relapse plan would look like and how they would know they needed help. The discharge facilitator also visited people who were on the waiting list for admission to offer off-site support to individuals and families while waiting for a bed. This approach has been successful as due to the facilitator's input, admission was no longer required. We will look at how this role progresses on our next visit.

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

Multidisciplinary team (MDT)
The wards have a broad range of disciplines who are either based there or accessible to them. The MDT used a standardised template to record meetings and these were held on Care Partner. At the time of our visit, there were five consultant psychiatrists who provided care for people on the wards; MDT meetings took place four days a week.

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and give their views. Attendees were from the medical and nursing teams, psychology, occupational therapy, social work, and any other support services involved with the person's care or discharge. The MDT meeting also included the individual and their family/relative, should they wish to attend. We could see that the discussions and decisions at the weekly multidisciplinary (MDT) meetings linked to the care plans.

It was not always clear who was responsible for the actions from the MDT but we discussed this with the service manager who advised that while this had previously been problematic, this was now resolved. What was clear to see in the notes was when the person was moving towards discharge, or not if that was the case, and where community services, who also attended the meetings, were involved.

We spoke with psychology staff who told us that there had been an increase in staff provision. They spoke about the stability in the team that allowed for ongoing service development. Access to psychology services was on a referral basis and there were dedicated staff for each ward.

It was clear from our discussions that psychology was an integral part of the multidisciplinary team, particularly in Ward 4. We also heard how psychology staff were supporting the learning for staff and families. Planning was underway to build a training strategy, with coaching that followed up on psychological skills such as trauma-informed care. This is likely to have a reflective practice element to it. For now, reflective practice is supported by the team on a case by case or informal basis.

Use of mental health and incapacity legislation

On the day of our visit to Ward 3, seven of the people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). In Ward 4, three people were detained.

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. In Ward 3, we were concerned that the certificates authorising treatment (T3s) were not in place. We spoke with one of the

consultant psychiatrists on the day of our visit and advised that urgent action was required to ensure that medications were lawfully authorised.

Recommendation 3:
Medical staff should ensure that they are familiar with the Commission's guidance in relation to Part 16 of the act and where a T3 certificate is required, all prescribed medication is appropriately authorised on this.

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. We did not see any recorded named person information.

A number of people on the wards were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). In Ward 3, we did not see any copies of power of attorney (PoA) or welfare guardianship orders on file. We raised this with the SCN who told us that staff had spoken with the family and requested they bring in a copy for upload to Care Partner. In Ward 4, there was evidence of PoA documentation and welfare guardianship orders stored on Care Partner.

Recommendation 4:
Managers responsible for Ward 3 should ensure that enquiries are made on admission as to whether there is a power of attorney or welfare guardianship order in place. Where this is the case it should be recorded in the care plan and a copy of the powers held on file.

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.

Rights and restrictions

Wards 3 and 4 operate a locked door policy, equal to the level of risk identified in the wards. Access to the wards is by buzzer entry from the outside and exit from the ward is by using an internal EXIT switch.

Advocacy services were available as required to people in both wards and information was provided to relatives who needed or wished to contact this service independently.

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 person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. There were no specified persons on the ward on the day of our visit.

When we review individual records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and s276 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. On the day of our visit, we did not see any advance statements on file.

On the day of our visit, there were two people in Ward 3 who were subject to continuous intervention who required an enhanced level of support. This support reflects NHS Ayrshire & Arran Framework for interventions, which was implemented in May 2025. Ward 4 had no individuals requiring interventions under this framework.

The Commission has developed *Rights in Mind.* 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

On our previous visit we made a recommendation for the consideration of creating a dedicated ward-based activity co-ordinator post to support the ongoing development of activity provision in the wards. This has not progressed, however, in Ward 4 there was an extensive activity programme over six days of the week, with Sunday being considered a "lazy day". In Ward 3, there was limited evidence of activities, with input from occupational therapy and arts/crafts input weekly but little else noted. We were told by one person in Ward 3 that they were "bored stiff" and that the arts and crafts were "pathetic and child-like".

Recommendation 5:
Managers responsible for Ward 3 should again consider creating a dedicated ward-based activity co-ordinator post to support the ongoing development of activity provision in the ward.

We also made a recommendation to review the level of occupational therapy input to ensure that this was adequate in meeting the clinical needs for those in the wards and that it should provide maximum benefit. This recommendation has been progressed and there was an additional Band 6 occupational therapist in post to provide an increased range of activities and interventions. This post also supports planning for discharge, promoting and maintaining functional skills, re-establish interests, socialisation, reducing the risk of de-skilling and the need for packages of care on discharge.

Most of the activities took place either in ward areas or the hospital grounds. There were occasions where people would be taken to their own homes for an assessment

prior to their discharge where the focus was on their abilities to cope out with the ward setting.

The physical environment

Woodland View is a purpose-built hospital that provides care for people who have mental illness and/or mental disorder; it opened in 2016.

The physical environment of the wards was of a high standard. The entrance was warm and inviting. Both wards are almost identical and there are meeting and visitor rooms near the main door where private meetings can take place. The kitchen and dining areas were bright and spacious. Bedroom areas were generously proportioned single rooms with en-suite showering and toileting facilities. We noted that many of the rooms had been personalised and there were reminders of home in the bedroom areas.

There was a separate bathroom containing a bath and a hairdressing sink which could be used for people who preferred a bath or who had difficulty getting their hair washed using a showerhead.

There was also access to several small lounges and seating areas out with the main lounge that offered a low stimulus area, if required. There were large, enclosed gardens in a courtyard setting that provided opportunities for activities in a calm, outside space. In Ward 4, we briefly spoke to an individual who was actively gardening, although they declined to talk in detail to us.

In both wards, posters were prominently placed about our visit and this had been followed up by staff speaking with the people on the wards asking if they would like to meet with us. The staff had also spoken directly with relatives and carers, encouraging them to speak to us either on the day of the visit or at a time more suited to them.

Summary of recommendations

Recommendation 1:
Managers responsible for Ward 3 should undertake regular audits of the care plans to ensure these are person-centred and updated to accurately reflect an individual's current needs and planned interventions.

Recommendation 2:
Managers responsible for Ward 3 should ensure that risk assessments and risk management plans are audited and reviewed on a regular basis.

Recommendation 3:
Medical staff should ensure that they are familiar with the Commission's guidance in relation to Part 16 of the Mental Health Act and, where a T3 certificate is required, all prescribed medication is appropriately authorised on this.

Recommendation 4:
Managers responsible for Ward 3 should ensure that enquiries are made on admission as to whether there is a power of attorney or welfare guardianship order in place. Where this is the case, it should be recorded in the care plan and a copy of the powers held on file.

Recommendation 5:
Managers responsible for Ward 3 should again consider creating a dedicated ward-based activity co-ordinator post to support the ongoing development of activity provision in the ward.

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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