Mental Welfare Commission for Scotland

Report on an unannounced visit to:
Ward 6, Woodland View Hospital, Kilwinning Road, Irvine, KA12 8SS

Date of visit: 9 September 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 6 is an eight-bedded unit situated in the purpose-built Woodland View psychiatric hospital in Irvine, North Ayrshire. The unit provides psychiatric assessment and treatment in low secure conditions for men suffering, primarily, from mental illness, learning disability and personality disorder.

On the day of our visit, there were eight people on the ward and there were no vacant beds. All individuals were subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedures (Scotland) Act, 1995 (Criminal Procedure Act).

The ward accepts referrals from other health boards in Scotland and when we visited, one person was placed out with their own health board area. On the day of our visit there were no delayed discharges.

We last visited this service in July 2024 on an announced visit and made no recommendations.

Who we met with

We met with, and reviewed the care of five people, two who we met with in person and three who we reviewed the care notes for. As this was an unannounced visit we did not meet or speak with any relatives.

We spoke with the deputy senior charge nurse, two staff nurses and a health care support worker. We also spoke with the ward doctor.

Commission visitors

Anne Craig, social work officer

Lesley Paterson, senior manager (East team)

What people told us and what we found

We met with two people and one of the individuals was keen to tell us that they “like it better here (than where he was previously)” and that they “felt safer here”. Another, who was only recently transferred to the ward, told us that the ward was “a great wee place”.

Staff we spoke to said that it was a good place to work. We were told about the support staff were receiving to further their careers; one was undertaking a master’s degree and another said that the support they were receiving while undertaking their degree in mental health nursing was very valuable and that the managers were very supportive.

Care, treatment, support, and participation

Care records

Electronic records were stored on Care Partner. Detention and treatment paperwork was duplicated in a paper file for ease of access. Care Partner was easy to use and information is readily accessible. The records that had most recently been uploaded to the system were immediately available.

Care plans were holistic, person-centred, detailed and reflected the goals and objectives for individuals. When care plans had been reviewed and/or updated, these were clear, they reflected changes made and who was responsible for taking these changes forward.

We noted several people were working towards moving to a rehabilitation ward in Woodland View and individualised support was being provided with this outcome in mind. We saw evidence of one-to-one sessions in the care notes and that these sessions also took place while the individual was out with the ward.

We also saw care plans in place where there were concerns about physical health. These were detailed and included actions that could/should be taken when a person became physically unwell.

We saw robust risk assessments on file reflecting the Ayrshire Risk Assessment Framework which was introduced in May 2025.

Multidisciplinary team (MDT)

We could see that care plans linked to the discussions and decisions at the weekly multidisciplinary (MDT) meetings.

There was evidence of discussions with individuals and their families detailed in the MDT notes, where appropriate. There had recently been a change in consultant psychiatrist and we were told that over the next few weeks, they were taking time to

get to know the people on the ward. Referrals for additional services are made on an individual/as required basis.

We were told that at this time there is no psychology input to the ward due to a vacancy. This is under active recruitment and we hope to see this service in place on our next visit.

Use of mental health and incapacity legislation

On the day of the visit, all those on the ward were detained either under the Mental Health Act or the Criminal Procedure Act; all were actively managed under Care Programme Approach procedures.

Those that we spoke to were aware of their status under the specific legislative framework and we were told that they had access to advocacy support. There was no information on display about advocacy but we were told that at the time of admission, this is discussed with the individual and if it was requested or felt to be of benefit, a referral was made for them.

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.

T2 and T3 certificates were kept in a separate folder in the staff duty room. We suggested the folder should be kept in the treatment room to allow for ease of access when checking the correct authority is in place when dispensing medication. We will look for this on our next visit.

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. One person had an AWI Act section 47 certificate in place, with a completed treatment plan.

Rights and restrictions

Ward 6 is a low secure ward and operates a locked door policy, equal to the level of risk identified in the ward. Access from the main corridor is by buzzer entry into a holding area and access and exit from the ward area is by air lock type entry system overseen by staff. Exit back into the main corridor is by EXIT switch.

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

specified 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 there were no reasoned opinions in place. There was no evidence of the individuals being formally advised of their specified person status and there seemed to be some confusion in the staff team of how and when specified person status should be applied and by whom.

Recommendation 1:
Managers should ensure that where specified persons procedures are implemented, the relevant paperwork, including reasoned opinion is completed, reviewed and audited.

Recommendation 2:
Consideration should be given to MDT training in the application and use of specified person legislation. The Commission has produced good practice guidance on specified persons[1].

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. Several of the individuals whose records we reviewed had named persons and two had advance statements on file. We were told that these were mostly on file from previous establishments; we asked that a review be considered during the person's admission and prior to moving on. We look forward to seeing this when we next visit.

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

At this time, Ward 6 does not have a dedicated occupational therapist who would normally oversee activities for the people on the ward.

We were told that the nursing team provide as much activity as they can in their clinical time, but we were told by one person and noted comments in the care records that individuals in the ward find it difficult to fill their time.

[1] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

The ward has a well-equipped gym that the individuals can access by request; they are currently waiting for a delivery of weights. There are large, enclosed gardens in a courtyard setting that provided opportunities for activities in a calm, outside space.

There are also outdoor areas with basketball hoop and a goal posts. The outside areas need structure and maintenance and we were told that this is in being progressed soon. Many of the individuals benefit from escorted and unescorted time off ward and this currently has been the mainstay of activity for them.

Individuals with access out with the ward benefited from the other amenities in Woodland View, including the shop, cafe area, library, psychological therapies hub and visits into the local town. There was a walking group and a cooking group where people are assisted with cooking and they particularly enjoyed the “fakeaway” sessions. A low intensity psychological therapy group was running for people on the ward and where they could attend and meet with individuals from other wards. We were told this can be beneficial in supporting transition to other units in the hospital.

We were told that the vacant occupational therapist post is being actively recruited to. We hope that on our next visit that this post will be filled, providing structured, meaningful activity to the individuals on the ward.

The physical environment

Woodland View is a purpose-built hospital which opened in 2016 caring for people who have mental illness and/or mental disorder.

The physical environment of the ward was of a high standard. The entrance to the wards was warm and inviting. There were meeting rooms and visitors’ 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. There is also a separate bathroom containing a bath which can be used for people who prefer this option.

There was also access to several smaller lounges, and seating areas out with the main lounge that offered a low stimulus area, if required.

We noted that many of the rooms had been personalised and had reminders of home.

Any other comments

As this was an unannounced visit to the ward we were unable to speak to relatives. We witnessed staff who knew the people on the ward well and we saw open, caring and supportive interactions. The atmosphere on the ward was light and jovial.

We asked about the policy of no smoking in the grounds of the hospital and we were told that this had not been a problem in the ward setting. Most people had come to

the ward from another clinical area, or hospital, and prior to their arrival were made aware of the policy and that this was now legislation in Scotland.

Summary of recommendations

Recommendation 1:
Managers should ensure that where specified persons procedures are implemented, the relevant paperwork, including reasoned opinion is completed, reviewed and audited.

Recommendation 2:
Consideration should be given to MDT training in the application and use of specified person legislation. The Commission has produced good practice guidance on specified persons[3].

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)

[3] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

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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