Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 10, Woodland View Hospital, Kilwinning Road, Irvine, KA12 8SS

Date of visit: 1 July 2026

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 10 is a 20-bedded, mixed-sex general adult acute admission ward which provides care and treatment for individuals diagnosed with psychiatric illness. The ward, based at Woodland View Hospital, which was purpose-built in 2016, serves the population of South Ayrshire; Ward 10 provides full multidisciplinary assessment and treatment for individuals on their journey towards recovery and discharge into the community.

On the day of our visit, there were 18 people on the ward and two vacant beds.

We last visited all three general adult acute admission wards in September 2024. This visit was an announced visit to Wards 9, 10 and 11 although this report will focus on Ward 10.

We were told that people on the ward were from all areas in Ayrshire and that it is a "catch all" for anyone requiring in-patient psychiatric care at Woodland View. On the day of our visit there were eight people in Ward 10 who were unable to access a bed in their home ward.

Recommendations from the last visit were that care plans should be audited and reviews clearly documented, carers' views should be included throughout all documents, all welfare guardianship or Power of Attorney (POA) documentation should be available on the ward, nursing staff should have a working knowledge of welfare guardianship orders and POAs and when people are subject to Adults with Incapacity (Scotland) Act, 2000 legislation, section 47 certificates and documentation was completed and on file.

The response we received from the service was that care plan audits had been implemented, nursing teams were working with the engagement officer from the Health and Social Care Partnership (HSCP) and advocacy services to audit family and carer involvement and experiences of acute adult mental health inpatient areas.

We were also told that processes would be developed that enabled new guardianship orders to be shared with health and uploaded on to the electronic information system, Care Partner.

On completion of a training needs analysis, development, and completion of training to nursing teams would be regularly repeated and a review of need for section 47 certificates would be included in standard multidisciplinary team (MDT) meeting review format.

On the day of this visit, we wanted to follow up on the previous recommendations.

Who we met with

We met with and reviewed the care of seven people, six who we met with in person and one who we reviewed the care notes of. We also met with one relative.

On the day of our visit, we spoke with the senior charge nurse (SCN), the charge nurse and two student nurses. We also met with the clinical nurse manager and the hospital manager.

Commission visitors

Anne Craig, social work officer

Karen Beattie, nursing officer

What people told us and what we found

On the day of our visit, people we spoke with were positive about their care and treatment. We witnessed warm and interactive interventions by the nursing team with the people on the ward.

One person told us that “staff are very good, nice, helpful” and another person said that they “feel safe and that I don’t know where I would be without them”. Another person said that “there are some good staff and some bad staff” and that they were “good to talk to and always about”. One person told us that their experience of being in the ward “wasn’t the greatest” and the ward was “hectic”. People told us that the food was good, others were less complimentary saying that it was “okay” and that they “didn’t trust it”.

A relative whose loved one had been discharged made a visit to speak with the Commission officers as they felt it was important that their views were noted. They told us that “information from staff was excellent, with good support and communication. Staff cannot do enough and they are friendly but firm and respectful and encourage questions”.

We were pleased to hear that significant efforts have been made to ensure that carers and relatives are informed and included in a person’s recovery journey while they are in hospital. An engagement support officer, hosted by North Ayrshire HSCP, works across the three adult acute wards in Woodland View to highlight the significant role of carers and relatives in a person’s life.

Additionally, there is a carers’ champion in each ward who supports the role of the engagement officer by signposting and providing information to carers and relatives at ward level; information leaflets were available from the staff. Feedback forms have been developed and an analysis of the feedback will be used to by the service to enhance the experience of people admitted to hospital with mental ill health; there will also be an anonymous carers experience survey.

Some individuals were able to leave the ward unescorted or, when possible, staff escorted them to the garden area or around the grounds of the hospital.

We met with two student nurses who were coming to the end of their training. They told us that their placement on Ward 10 had been their best training experience. Their 16-week placement had allowed them to be fully integrated into the ward staff team and they were able to make meaningful connections with the people on the ward. Both students advised that they would like to be a full-time member of staff in Ward 10; this was because of the mentoring and support they had received from the full ward team.

Care, treatment, support, and participation

Information on individuals' care and treatment was held on Care Partner. All records are now electronic and paper files are no longer used. We found Care Partner to be intuitive and easy to navigate.

We could see from the records that care plans were detailed and person-centred. Care plans focused on the mental and physical health of the individuals and had clear links to multidisciplinary team (MDT) decision making. There was also a summary of the decisions made at the MDT meetings in the care notes.

When reviewing the care plans we found that the descriptions of interventions and input from the staff team was of what was being done for the person, rather than in collaboration with the individual. However, taking this in the context of the high acuity on the ward (eight of the 18 people on the ward had been admitted within a month of our visit) many people were extremely unwell and not able to collaborate or engage to any great extent with their care planning.

We could see that care plans were designed to include as much of each individual's views as it was possible to ascertain. It is expected that as people begin to recover, there will be a greater inclusion of the person in their care plan and the balance will change. We could see where a person had declined to approve or was unable to engage with the creation of the care plan as this was documented in the record.

Physical health needs were timeously addressed and followed up appropriately.

Daily care notes were well structured and detailed, with personal attributions from the individual, using quotes from them to illustrate how they were feeling and presenting at any given time. Care records had an alert system that detailed any strategies that were in place. Information boards in the duty staff room replicated the information from the care record.

We could see that, where appropriate, people on the ward had access to psychological therapy and there was detailed information if psychology was not being provided and why it was not felt to be useful at that time.

Risk assessments were robust and comprehensive; we found it easy to see where risks were identified using the Ayrshire Risk Assessment Framework. Reviews of risks assessments took place regularly.

We were pleased to hear that to ensure communication is optimised for people who are nearing discharge, the staff have created and are trialling a Transition Activity Record; this record will confirm what actions have been taken to promote safe discharge back to the community. The purpose of the record is that it recognises that the first seven days post-discharge is when people are at their most vulnerable. It is hoped that this tool will be able to be used by the community teams when a

person is admitted to hospital so that information sharing will be reciprocal. We look forward to hearing about the progress of this on our next visit.

Multidisciplinary team (MDT)
The MDT input to the ward consisted of medical staff, nursing staff, psychology, and occupational therapists (OTs). Social work staff attend the ward meetings as required and advocacy services attend on a referral basis. Pharmacy also offers regular input.

People in Ward 10 are cared for by four consultant psychiatrists dedicated to ward, however due to the ward having people from all over Ayrshire, MDTs are held most days of the week. We noted that on some occasions, the MDTs did not have a full complement of staff attending, particularly where the person was boarding from another ward; this did not appear to impact on the care and treatment provided. We heard from those who we spoke with that they regularly spoke to their doctor.

MDT templates reflected attendance at the meeting and the discussion that was held, which was also recorded in the care records of the individual; the MDT template reflected actions and the plan for the next meeting. Attendance of the individual was also recorded and it was acknowledged when the person had declined to attend.

Use of mental health and incapacity legislation

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act, 2003 (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 that was prescribed. T2s and T3s were maintained in a folder in the treatment room and there was evidence of audit and oversight by the MDT.

On the day of the visit, 11 of the 18 people on the ward were detained under the Mental Health Act. Most people we spoke with understood their legal status and were aware of the implications of this. Documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment, were up to date and available to view on Care Partner. We saw copies of correspondence informing people of their status and also when further compulsory measures were being sought.

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. There were two people who had a named person.

One individual was subject to the AWI Act and a copy of the welfare guardianship was on file and available to view.

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. For people on the ward who required a section 47, these were available to view on Care Partner.

Rights and restrictions

Ward 10 operates a locked door policy, commensurate with the level of risk identified with the patient group. Access was by buzzer entry from the outside and individuals could leave the ward using the exit button at the outer door.

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 an individual is a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied. Three people were subject to specified person restrictions for safety and security in hospitals and for telephone use. There was reasoned opinion in place and the forms for the restrictions were available to view on Care Partner.

On the day of our visit there were no individuals on continuous interventions. We spoke with the SCN, who discussed her role in supporting people who are placed on continuous intervention and how intrusive that must be for the person when this restrictive intervention is required to be put in place. In 2025, NHS Ayrshire and Arran implemented the Framework for Interventions guideline. This was recently reviewed and updated and the Ward 10 SCN has had a role in the review.

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 did not find any advance statements on file.

Activity and occupation

Ward 10 has a 'group' nurse who works three days per week and organises various activities for the people on the ward. Out with these times, the nursing assistants take people to the gym, go walks, play pool and table tennis. We found a record was made in an individual's notes if they have participated in groups.

When speaking to people on the day of the visit, there were no comments on the level of activity offered.

The physical environment

The ward consists of 20 en-suite bedrooms. These were surrounded by a well-maintained garden area that was visible through large glass panels which provided natural light into the ward.

The outside space, both the enclosed part in the ward and across the hospital site was well maintained. The building continues to feel fresh, with a high standard of décor and furniture.

Overall, the ward had a pleasant ambiance, creating a relaxed atmosphere. Posters were well placed, advising of the visit by Mental Welfare Commission.

Summary of recommendations

The Commission made no recommendations in this report.

Service response to recommendations

Although there are no recommendations from this report, the Commission would 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 an action plan which we would like returned within three months of the publication date of this report.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk