**Mental Welfare Commission for Scotland**

**Report on announced visit to:**

Ward 9, Woodland View Hospital, Kilwinning Road, Irvine, KA12 8SS

**Date of visit**: 9 June 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 9 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 Woodlands Hospital, which was purpose built and opened in 2016, 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 20 people on the ward and no vacant beds.

We last visited all three general adult acute admission wards in September 2024 and while this visit was an announced visit to Wards 9, 10 and 11, this report will focus only on Ward 9, which serves the population of North Ayrshire.

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 were to have a working knowledge of welfare guardianship orders and POAs when people are subject to the Adults with Incapacity (Scotland) Act, 2000 (AWI) legislation, including those who had a section 47 certificate, which should be 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 in North Ayrshire 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 and uploaded on to the electronic record system, Care Partner. On completion of a training needs analysis, development and completion of training to nursing teams would be regularly repeated and 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 two deputy charge nurses (DCN). We were unable to meet with the senior charge nurse, clinical nurse manager and 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 generally 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 a riot’ (in a positive sense) and that they were “good to talk to and always about”. Other people told us that “staff are fantastic given what they deal with on a daily basis” and “staff are nice, very nice”.

Some people we spoke with 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 were also told that people who smoked resented having to be escorted off hospital grounds to do so but also that, in their view, this did not happen often enough. People had been offered nicotine replacement therapies but this was often not enough to support them not to smoke.

People told us that the food was good, others were less complimentary saying that it was “okay”.

On the day of our visit, we were advised that there were four delayed discharges. One person was waiting for transfer to a hospital-based complex clinical care (HBCCC) ward and another waiting for community supports to be put in place. Accommodation and supports had been secured for another person and a discharge date had been set. One person had been delayed for around 2 years waiting for appropriate housing and we will discuss the delay for this person with the HSCP.

## Care, treatment, support, and participation

### Care records

Information on individuals’ care and treatment was held on Care Partner. All recordings 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 most care plans were detailed and person-centred but we found the quality and detail in some to be inconsistent. Care plans focused on the mental and physical health of the individuals and had clear links to MDT decision making. There was also a summary of the decisions made at the MDT meetings in the care notes.

We were pleased to see detailed person-centred care plans that evidenced the person’s involvement and also recorded where a person had declined to approve or engage with the creation of the care plan. The care plans provided a comprehensive account of each person’s journey and recovery.

Some people had physical health difficulties and there was clear focus on this, with associated care plans that reflected how people would be cared for. We saw that physical health care needs were being addressed and followed up appropriately.

**Recommendation 1:**
Managers should ensure that nursing care plans are person-centred and holistic, with a clear focus on mental health and well-being and that they evidence participation of the individual and/or carer in the care planning process.

We spoke with one relative during the visit and they praised the care and support that their family member had received. They told us that they felt involved with their son's care and acknowledged the complexity and range of care needs that the staff provided.

We discussed the specialised care of individuals with complex needs, such as acquired brain injury, with staff who acknowledged that further training and education would be beneficial.

On our last visit we made a recommendation about reviewing and auditing the care plans. We were told that the charge nurses complete five care plan reviews each month and we were provided with a copy of the template that was used so that we could see evidence that these were being undertaken. We also found helpful information contained in people's one-to-one discussions with their named nurse.

We were told that there is a dedicated inpatient psychologist in post. We could see that people on the ward had access to psychological therapy and there was detailed information about when psychology was not being provided and why it was not appropriate at that time.

Risk assessments were robust and detailed; we found it easy to see where risks were identified using the Ayrshire Risk Assessment Framework. We could see reviews of the risks assessments taking place regularly.

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.

**Multidisciplinary team (MDT)**
The multidisciplinary team (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.

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

People in Ward 9 are cared for by four consultant psychiatrists. MDT meetings take place between Monday and Thursday each week, with one consultant having an MDT each day.

MDT templates reflected who attended the meeting and the discussion from the meeting was recorded in the care records of the individual as well as on the MDT template, which reflected actions and plans for the next meeting. Attendance of the individual was also recorded and an acknowledgement when the person had declined to attend.

We were provided with a copy of the MDT pre-meeting checklist, completed by the nursing team prior to the meeting, which gave the current presentation of a person. The checklist then went on to consider the input from others, including input from HSCP and community mental health team (CMHT) colleagues.

The nursing staffing levels in Ward 9 were good, with maternity leave cover in place and only one vacancy for a health care support worker.

## Use of mental health and incapacity legislation

On the day of the visit, 16 of the 20 people on the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

Everyone we spoke with understood their legal status. Documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment were mostly up to date and available to view on care partner.

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 spoke with staff on the ward about two T3's that required to be raised with the RMO although they did not affect the treatment provision for the individual.

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. We saw evidence of one person having a named person.

Four people were subject to the AWI Act, with three having welfare guardianships in place and who were also detained under the MHA. One person, who was receiving their care on an informal basis had a POA. We were also told that a welfare guardianship order was pending for another individual on the ward who is also detained under the MHA.

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 those on the ward who required a certificate completed under section 47, these were available to view on Care Partner.

## Rights and restrictions

Ward 9 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 can leave the ward using the exit button at the inner door. The activity at the door was constantly monitored by a "floor nurse".

On the day of our visit to Ward 9, there were no individuals on continuous interventions and there were no individuals subject to specified person restrictions.

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 statements on file.

We discussed this with staff on the day and they advised that where the person is receptive to this discussion it is undertaken at that point in time, particularly when a person is being considered for discharge.

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

There were two 'group' facilitators on the ward, one of whom is on duty each day between 9:00am and 4:00pm. There was no set activity plan and activities reflected in individual likes/dislikes, presentation and abilities.

When we last visited, there were vacancies in the occupational therapy service which has now been resolved and along with nursing staff, they support individuals in activities.

There is a walking group and other planned group activities were varied, therapeutic and constructive. Some people we spoke with advised that in relation to activities

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

they were “bored”. Activity participation, or not, was recorded in the individual’s care notes.

## 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 that provides natural light into the ward. The outside space, both the enclosed part in the ward and across the hospital site is well maintained.

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:**
Managers should ensure that nursing care plans are person-centred and holistic, with a clear focus on mental health and well-being and that they evidence participation of the individual and/or carer in the care planning process.

### 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.

## Contact details

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