Mental Welfare Commission for Scotland

Report on announced visit to: Acute Assessment Unit and Intensive Psychiatric Care Unit, Langhill Clinic, Inverclyde Royal Hospital, Larkfield Road, Greenock, PA16 0XN

Date of visit: 12 July 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been unable to conduct our face-to-face visits, however this local visit was able to be carried out face-to-face.

The Langhill Clinic comprises of an Acute Assessment Unit (AAU) and Intensive Psychiatric Care Unit (IPCU). The AAU is a 20-bedded acute inpatient psychiatric assessment ward. An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation.

IPCUs generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often distressed patients. This IPCU has seven beds. There previously was eight, however one bedroom was recently changed into a de-escalation room. A de-escalation room is a safe, low stimulus room where patients can go if they are experiencing or exhibiting distressed behaviours.

Both units are for adults predominantly aged between 18 and 65 years, mainly from the Renfrewshire and Inverclyde areas. They offer mixed-sex facilities, with patients being accommodated in individual en-suite rooms.

We last visited these wards on 18 June 2019 and made four recommendations regarding reviewing the care plans of patients who had been in the IPCU for 12 months or more to ensure there are no deficiencies in care relating to lack of appropriate provision, addressing difficulties relating to access to psychology services and psychological therapies, creating personalised activity programmes which are tailored to patients interests and fixing an issue with cold showers.

On the day of this visit we wanted to follow up on the previous recommendations and also hear how the service had managed throughout the current Covid-19 pandemic, specifically in relation to the impact of restrictions, contact with relatives, reductions in opportunities for rehabilitative activities out with the ward and the mental health of patients. We also wanted to give patients an opportunity to raise any issues with us and to ensure the care, treatment and facilities are meeting patients' needs.

Who we met with

We met with six patients, reviewed the care and treatment of eight and spoke to some relatives. We met with three patients in the IPCU and three in the AAU. We also spoke with the mental health inpatient services manager, the senior charge nurse from each ward and some other members of nursing staff.

Commission visitors

Lesley Paterson, Nursing Officer
Mary Leroy, Nursing Officer
Dr Stephen Davidson, MWC attached higher trainee, psychiatrist

What people told us and what we found

Care, treatment, support and participation

On the day of our visit the IPCU ward had its full complement of seven patients, all of whom were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') and two of whom were on an enhanced level of observation due to their presentation and complex care needs.

We were told that providing this level of additional staffing can be very challenging to staff resources particularly as staff recruitment is difficult.

When we last visited, we highlighted concern and made a recommendation about the unacceptable length of time four patients had been in the IPCU. We were dismayed to find that three of these four patients remain here, two years later.

This is a significant issue of concern.

Whilst we know these patients have complex care needs which require a high level of intensive nursing input, IPCU's by their design are not intended for long-term admissions.

The small and enclosed environment of the IPCU allows for very limited recreational and exercise opportunities with limited facilities and opportunities to encourage and promote rehabilitation. There continues to be a lack of the specialist, more appropriate, longer term resources that these particular patients have been deemed to require. This needs to be addressed urgently by the health board as these patients are being significantly disadvantaged.

The MWC will be following up on these individual cases as a matter of urgency with the Responsible Medical Officer, Medical Director and Head of Mental Health Services in relation to these unacceptable lengths of admission.

Acute Assessment Unit

Only 13 of the 20 beds were occupied when we visited, which we heard was unusual. Of the 13 patients on the ward, six were detained under the Mental Health Act and two patients were being nursed on an enhanced level of observation.

We were informed that there continues to be good links with the community teams and the crisis team in relation to admissions and discharges. There appeared to be no particular difficulties in terms of patients returning to the community, and there were no patients listed as delayed discharges.

Across both wards, the majority of the patient records are stored on EMIS, an electronic records system and some information continues to be held on paper records. The IPCU has input from one consultant psychiatrist and the AAU has input from three consultant psychiatrists.

There is also input from occupational therapy (OT), physiotherapy and pharmacy with referral to salt and language therapy and dietetics when required. Each consultant hold a weekly multidisciplinary team (MDT) meeting. These meetings were recorded within the patients' notes with a clear note of discussion, outcomes and actions. There was input from the full team and in most cases, it was clear to see who attended. We were told that patients are not routinely invited into these meetings but can be part of the process if they wish, as can relatives, who can choose to be involved remotely.

Patient care plans across both wards presented a mixed picture. Some were very detailed, individualised and gave a good sense of the patient. Others were bland and contained repetitive statements. The paperwork used within both wards was inconsistent. There was, however, evidence of patient involvement and all were regularly reviewed. We also observed evidence that the physical health care needs of patients was being met, both within the care plans but also with regards to high dose antipsychotic therapy monitoring, clozapine, lithium monitoring and epilepsy. Risk assessments were robust and up-to-date. They appeared responsive to patients needs and there was a clear link between risk assessment, risk management, care and treatment.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

The patients we spoke to were generally positive about the care and treatment they were receiving and spoke positively about their relationships with nursing staff. One patient told us they were grateful for the time and patience staff display when helping them to access books and DVDs. We did hear some comments about staff using their mobile telephones during their shift and we raised this with managers on the day of the visit, but overall, most comments were positive. It was clear when talking to nursing staff that they know their patients well.

On our last visit to the clinic we made a recommendation that managers should address difficulties relating to access to psychology services and psychological therapies; however, we were disappointed to find that the situation remains unchanged and there is currently no dedicated psychology provision to either ward. Some members of nursing and OT staff are trained / are undertaking training in psychological therapies, however are not currently able to deliver these due to the lack of available supervision.

The continued lack of availability of psychologist input and psychological therapies can only have an adverse impact on patient care and is not congruent with the principles underpinning the Mental Health Act, such as benefit and reciprocity.

A significant issue for patients and families across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting.

Staff at the Langhill Clinic staff have continued to encourage family contact between patients and their families as far as possible and patients have been able to maintain telephone or

video call contact where appropriate, with a move towards face to face when restrictions allowed.

On our last visit to the clinic in June 2019 we heard that the service was working to improve contact between relatives, carers and the clinical team. Whilst we did see some evidence of carer involvement at MDT meetings, this was limited and there was little evidence of contact with carers out with meetings and no formal engagement structure. It is fundamental that carers and relatives are informed, included and involved in care and treatment as appropriate to not only address and meet the needs of carers, but also to improve the treatment outcomes for patients.

Recommendation 1:

Managers should formally review the care and treatment plans of all patients who have been in the IPCU for six months or more.

Recommendation 2:

Managers should address the difficulties relating to access to psychology services and psychological therapies.

Recommendation 3:

Managers should improve and formalise engagement with carers.

Use of mental health and incapacity legislation

As mentioned already six patients within the IPCU and six within the AAU were detained under the Mental Health Act. Part 16 (S235-248) 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.

Not all the correct paperwork was in place and not all paperwork which was in place corresponded with the prescription paperwork. We discussed these specific issues with managers on the day.

Recommendation 4:

Managers and RMOs should:

- review all current consent to treatment (T2 and T3) certificates to ensure they are appropriate
- ensure T2 consent forms are present where required and that DMP visits are arranged where required for T3 certificates

Recommendation 5:

Managers should put an audit system in place to ensure that consent to treatment certificates are in place where required.

Rights and restrictions

The IPCU is a locked ward and, as we would expect, all but one of these patients were detained under either the Mental Health Act or the Criminal Procedure (Scotland) Act 1995. We do, however, continue to be concerned about the length of stay of many of the patients, as this ward is not intended for long-stay patients, as outlined in our earlier recommendation. As mentioned, the IPCU now has a de-escalation room.

We would expect that wards, which impose restrictions to patients' freedom of movement, develop a policy on use of seclusion with reference to our guidance. We were told that the IPCU's seclusion policy is currently in draft form and we request that this is forwarded to us on completion.

The AAU had a mix of informal and detained patients. The door to this ward was not locked and patients who were not detained were able to come and go freely from the ward. We saw evidence of discussions with patients regarding their rights, consent, and time spent off the ward and a patient information leaflet was made available to every patient on admission to the ward.

Section 281 to 286 of the Mental Health Act provides a framework within 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. There were no patients subject to specified person legislation in the AAU and three patients subject to this legislation in the IPCU. In each of these cases the restrictions were legally authorised and the need for these restrictions were documented and regularly reviewed.

We were told that there is good access to advocacy service and patients who use this found it to be responsive, helpful and supportive.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Therapeutic Activity and Occupation

The AAU appear to have good input from OT, with two OTs, although one is currently on long term leave. The patients we spoke to spoke highly of the variety of activities which were on offer, which included cooking groups, relaxation, walking, arts and crafts but felt that more sessions could be offered. We also heard the ward now has access to a mini bus which has improved access to community facilities.

We heard that there is currently no dedicated OT cover for the IPCU; however they do have access to an activity coordinator six sessions per week. We heard that this is going really well

and they have worked closely with some patients who had previously been reluctant to engage in activities. The activity coordinator post is temporary but there is a hope that this can be made substantive and be rolled out to the AAU too. Patients in the IPCU were not so positive when it came to describing the activities on offer with two commenting that the days were long and boring with little to do. Unfortunately there was also little evidence in the patient records of activity planning or participation in structured activities. Whist we agree that the input from a patient activity coordinator is a welcome addition, we feel this area requires more work.

Recommendation 6:

Managers should ensure that patients (particularly in the IPCU) have activity addressed in their care plans; these plans require to be person centred reflecting the individual's preferences and care needs.

The physical environment

These wards are purpose built and patients have individual rooms with en-suite facilities. Rooms are spacious and bright, and all of the patients we spoke to seemed happy with the accommodation provided. The AAU has ample communal space and quiet areas.

Both wards have access to well maintained, enclosed garden areas which we heard are well used by patients. The only issue we noted with the environment was the temperature was very hot within both wards.

There was a lack of air conditioning or free flowing air. Patients and staff described the heat as being at times 'stifling' and spoke about how this can have a detrimental impact on patients' mental health as well as the importance of effective ventilation on the infection prevention and control situation with regards to Covid-19. The NHS GGC Estates team have submitted an options paper and considering how the installation can take place, avoiding disruption to patient care whilst the environmental works are undertaken. There is no timescale for completion of the works

Recommendation 7:

Managers should address the temperature regulation within the clinic to achieve effective ventilation for the comfort, health and safety of staff and patients.

Summary of recommendations

1. Managers should formally review the care and treatment plans of all patients who have been in the IPCU for six months or more.
2. Managers should address the difficulties relating to access to psychology services and psychological therapies.
3. Managers should improve and formalise engagement with carers.
4. Managers and RMOs should:
    - review all current consent to treatment (T2 and T3) certificates to ensure they are appropriate
    - ensure T2 consent forms are present where required and that DMP visits are arranged where required for T3 certificates
5. Managers should put an audit system in place to ensure that consent to treatment certificates are in place where required.
6. Managers should ensure that patients (particularly in the IPCU) have activity addressed in their care plans; these plans require to be person centred reflecting the individual's preferences and care needs.
7. Managers should address the temperature regulation within the clinic to achieve effective ventilation for the comfort, health and safety of staff and patients.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Alison Thomson
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 MWC 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 individual care, treatment and support is 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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