Mental Welfare Commission for Scotland

Report on unannounced visit to:

Acute Adult Assessment Unit and Intensive Psychiatric Care Unit, Langhill Clinic, Inverclyde Royal Hospital, Larkfield Road, Greenock, PA16 0X

Date of visit: 1 February 2023

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Langhill Clinic comprises an eight-bedded intensive psychiatric care unit (IPCU) and a 20-bedded adult acute assessment unit (AAU), with a mix of patients ranging from those who were acutely unwell to those patients who were preparing for discharge.

We last visited this service on 12 July 2021 and made recommendations about reviewing care plans, access to psychology services, engagement with carers, completion and audit of consent to treatment forms, activities for patients and the temperatures within the ward areas.

The response we received from the service provided updates on activity in relation to the recommendations; we were advised that transfers from the IPCU had taken place shortly after our visit and an additional psychology post had been agreed but was still to be recruited to. There had been training on engagement with carers and quality assurance arrangements and monitoring had been put in place. Robust arrangements were put in place to support person centred care planning and discussion had taken place with NHS Greater Glasgow and Clyde estates team regarding the ward temperature.

Who we met with

We met with, and reviewed the care of nine patients across both wards, six who we met with in person and three who we reviewed the care notes of. We did not speak with any relatives during this visit.

We spoke with the senior charge nurse in IPCU and the nurse-in-charge in the AAU. We spoke retrospectively with the service manager.

In addition, we spoke with the activities co-ordinator who covered both wards.

Commission visitors

Anne Craig, social work officer

Margo Fyfe, senior manager

Douglas Seath, nursing officer

Justin McNicholl, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

This was an unannounced visit to IPCU and AAU. There were no senior staff on duty in AAU and the ward was very busy with staff responding to incidents throughout the day. Our view was that the staff team on duty would have benefitted from having a senior member of staff on duty at all times, mainly due to the high acuity of the patients, the numbers of enhanced observations and what appeared to be the relative inexperience of the staff. However, during these incidents we noted a calmness from the team who continued to undertake their duties in a thoughtful and supportive way, both to the patients and with their peers.

Throughout the visit we saw kind and caring interactions between staff and patients. Staff that we spoke with knew the patient group well. It was good to note that the patients we met with praised the staff highly and were mostly complimentary; one patient commented that they attributed the greatest part of their recovery to the input from the nursing team rather than their consultant, although acknowledged that the psychiatrist was only part time in AAU.

We heard from staff that during the pandemic, the restrictions created a reduction in visitors to the unit; the patients benefitted from this as they had fewer people to cope with in their living space. Visitors to the unit continues to be minimised and visits take place in the dedicated visitor's room which was light and bright. One patient commented that this allowed visiting from their children, which was important to the individual's wellbeing.

We were told that the food was good although one patient required Halal food and this seemed to be difficult to obtain.

Recommendation 1:
Managers should ensure that for patients who have particular dietary requirements, there is range of healthy and varied options.

Previously we had been concerned about patients whose discharge had been delayed and who had been on the ward for extended periods of time, particularly in IPCU. While we noted that at the time of this visit there were two patients whose discharge was delayed, their needs were complex and there were ongoing efforts to seek the most appropriate placement for them.

There were good links with local services, the health and social care partnership, community mental health teams and the community learning disability services in particular. Two patients were receiving in-reach support from the learning disability team and support workers visited the ward to provide care and give advice to the staff team.

In IPCU, the senior charge nurse advised us that there was a good ratio of staff to patients, there was a reasonably settled workforce with no issues with staff retention. We noted that there were a mix of patients, with some who were chronically mentally unwell, others with forensic needs and some patients who had been in the ward longer than we would expect. On the day of our visit there were two patients on enhanced observations, with one patient that required additional support; the senior charge nurse commented that mainly this is managed with the staff on duty in the unit.

On the day of our visit there were five patients on enhanced observations in the AAU. With this number of patients requiring additional support, there was an impact on staffing although we observed a good ratio of staff to patients even though the ward was extremely busy. We were also aware that staff from other wards were re-directed to support the ward team. We found that observations were unobtrusive for all patients on the ward, with staff located in areas where there were higher risks. On the day of our visit there was one vacant bed and one room out of order for decorating.

When we last visited the service we made recommendations about the care and treatment plans. On this occasion, we found detailed person-centred care plans that evidenced patient involvement. The care plans were relevant, they were up-to-date and the reviews were timely with evidence of forward planning. In the IPCU, care plans and reviews of patients who had been in the unit for a lengthy period of time were not of the same quality; we discussed this with the senior charge nurse on the day.

We were advised that AAU patients did not have their own copies of their care plan although this would have been available to them if they had wished to see it. Care plans were updated at the MDT where the patient was able to have input to the meeting, and their updated document.

Recommendation 2:
Managers should regularly audit care plans across the service to ensure they are up-to-date, are person-centred and include all the individual's health and care needs.

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/node/1203

We saw that physical health care needs were being addressed and followed up appropriately.

Multidisciplinary team (MDT)

IPCU has input from one part-time consultant psychiatrist, while the AAU has a input from three part-time consultant psychiatrists. Both wards have a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, and speech and language therapy staff. Psychology input continues to be an area of concern and at the time of our visit there was no dedicated psychology service for the patients other than ad-hoc input to particular patients from the community team. We raised this with the service manager on the day and were informed that the appointment for a permanent dedicated psychologist had been made and the successful candidate was due to commence in early March. We look forward to seeing their input with the patients on our next visit. Referrals can be made to all other services as and when required.

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 provide an update on their views. This also included the patient and their families should they wish to attend. It was clear to see from these notes that when the patient was moving towards discharge that community

services also attended the meetings. The MDT notes were informative and of good quality, and we were pleased to see that they also included a forward plan.

We heard that meetings had been held online during the restrictions and that this had enabled more professionals to attend. At the time of our visit MDTs have resumed face to face and they also provide a hybrid arrangement via MS Teams for those unable to attend and will include families and carers.

Care records

Information on patients' care and treatment was mainly stored on the electronic record system, EMIS, although some information continued to be held on paper records. We discussed this on the day of the visit and were assured that discussions were ongoing with the IT department to ensure that in future, most information could be saved to the EMIS system. Care records were detailed, appropriate and recorded in a timely manner.

We also found a good deal of information contained in one-to-one discussions with patients and their named nurse. We saw robust risk assessments that were comprehensive and up-to-date.

We were told by the service manager that there were plans to put more of the paper records on to electronic patient records and to add a further four templates to EMIS including MUST, (Malnutrition Universal Screening Tool) and a falls risk assessment.

Use of mental health and incapacity legislation

On the day of our visit, 18 of the 26 patients in the two wards were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The patients we met with during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act.

All documentation pertaining to the Mental Health Act was reviewed and was mostly in place; where there was discrepancy, this was brought to the attention of the senior charge nurse for correction.

Part 16 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. 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 found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date.

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. Where a patient had nominated a named person, we found copies of this in the patient's file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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. There was one patient that required treatment under AWI and we noted a discrepancy between the section 47 certificate and the electronic prescribing record. This was raised with the nurse-in-charge and we advised that this should be updated as a matter of urgency.

Rights and restrictions

The IPCU operated a locked door policy, commensurate with the level of risk identified in the patient group. Access to the ward was restricted and staff admitted visitors personally, locking the outside door before unlocking the door to the ward.

The AAU is accessed by a buzzer outside the main door, the door code is noted in the unit and on the buzzer for patients and visitors to use in order to exit the ward.

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 patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where a person was specified, and restrictions were in place under the Mental Health Act, we found reasoned opinions in place. On the day of our visit, for those patients who were specified persons in both wards, all appropriate paperwork was in place.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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 see any advance statements on file for patients and would urge staff to discuss the making of such statements with patients as they are nearing the end of their stay in the units.

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

Activity and occupation

We heard from some patients that there was nothing to do, and one patient felt that the activity co-ordinator could be more pro-active in engaging patients with activity. We were told that an activity such as meditation was particularly welcome as patients found this to be extremely beneficial but it was offered on an ad-hoc basis. We heard from the patient activity co-ordinator that in IPCU there is no dedicated area to undertake any activity-focussed interventions. We heard that when patients wished to access gym equipment they had to leave the ward and go downstairs. Patients who wanted to go to the gym needed to be escorted by a member of staff, and the staff then had to remain with them whilst using the equipment. Other patients commented positively on the support from occupational therapists on the ward, which they was felt beneficial and mood enhancing. In discussion with the service manager,

we were advised that funding had been agreed to increase the current part time occupational therapy post to full time. We look forward to seeing an improvement in the activity provision with this increase.

The physical environment

In both wards, there were single en-suite rooms. There was a lounge area and a separate dining area for the patients. We felt that the main ward spaces, which were in the centre of the ward, had little or no natural light; we found them to be dark and unwelcoming.

Some patients commented on the environment of the wards and it was clear that many of the open spaces and some of the rooms required upgrading and decoration. We were told there was a rolling programme of decoration, and saw one of the painters on his way into the ward. To the rear of AAU there was a garden space that could be utilised by patients, although we noted that this was bland and required some work to be undertaken. We consider that it is important for patients to have access to well-maintained, outdoor safe space.

Recommendation 3:
Managers should ensure that patient areas are welcoming and homely. They should have regular maintenance and upgrading to ensure that patients care is in a therapeutic and safe environment.

Recommendation 4:
Managers should ensure that any outside area that is accessed by patients is welcoming, maintained and safe.

Summary of recommendations

Recommendation 1:
Managers should ensure that for patients who have particular dietary requirements, there is range of healthy and varied options.

Recommendation 2:
Managers should regularly audit care plans across the service to ensure they are up-to-date, are person-centred and include all the individual's health and care needs.

Recommendation 3:
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Recommendation 4:
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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 Health 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 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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