Mental Welfare Commission for Scotland

Report on announced visit to: Inverclyde Royal Hospital, Wards 4 A and B, Larkfield Unit, Larkfield Road, Greenock, PA16 0XN

Date of visit: 11 April 2024

Where we visited

Ward 4 is located on the first floor of the Larkfield Unit, which is part of the district general hospital. The unit has 20 beds for the assessment of older people and is designated as short stay unit. The ward is divided into two sub-units; 4A has capacity for 10 beds for people with dementia and 4B has 10 beds for people with other mental illnesses.

On the day of our visit, there were 11 people across the wards. Bed numbers have been capped at 16 due to medical staffing issues.

The ward catchment area is co-terminus with Inverclyde local authority.

We last visited this service in July 2023 on an announced visit and made nine recommendations in relation to record keeping, communication, and involvement of families and proxy decision makers, care planning and life histories, activity provision, and laundry.

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 nine people, seven who we met with in person and two who we reviewed the care notes of. We also met with two relatives.

We spoke with the service manager, the senior charge nurse, and members of the nursing team.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

Mary Leroy, nursing officer

Paul MacQuire, nursing officer

What people told us and what we found

The relatives we spoke with were complimentary about nursing staff. They felt that they were welcome on the ward and were encouraged to be involved in their loved ones' care. They felt staff were generally very caring and there were a couple of staff whom they felt "would go above and beyond, and really got things moving" However they did feel that communication from both medical and nursing staff could be more proactive. While they did speak to medical staff regularly, they had not been invited to any of the multi-disciplinary meetings.

One of the patients we spoke with described staff as easy to talk to. When asked if anything could be improved, we were told "no, they know what they were doing, they reassured me and kept me safe".

We also heard positive comments about the quality of the food.

We were told that the ward is about to be decanted to allow for redecoration and refurbishment, which is welcome. The exact dates and location of the decant has still to be confirmed.

Care, treatment, support and participation

Care records

Information on patients' care and treatment was held in three ways. There was a paper file, the electronic record system EMIS, and the electronic medication management system. Care plans and nursing reassessments were held in the paper system. Multidisciplinary team reviews and chronological notes were held on EMIS, along with paperwork for the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Transitioning across to a fully electronic system is planned, with one of the local mental health wards currently involved in a pilot to move to electronic person-centred care plans. We look forward to seeing this fully implemented across the service.

We previously made recommendations in relation to nursing care plans. During this visit, we found robust initial assessments and risk assessments in all of the records we reviewed. These informed the very comprehensive, person-centred care plans which were regularly updated to reflect changes in needs and care delivery. Physical health needs were addressed in care plans we reviewed; these were person-centred and gave a clear picture of the individual's skills and abilities.

We reviewed the files of several patients who experienced stress and distress and were prescribed as required medication for this. We found detailed Newcastle formulations completed for these individuals, and there were care plans for managing their stress and distress that referenced this and contained detailed information on specific triggers and management strategies to use with each individual. The Newcastle model is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge.

We found completed 'Getting to Know Me' forms in the files we reviewed and completed 'What Matters to Me' information beside each bed. Relevant life history information was

documented either in initial assessments, or in Newcastle formulations where these were in place.

Multidisciplinary team (MDT)

The ward has regular input from psychiatry, psychology, occupational therapy, and pharmacy. Other allied health professionals are available on a referral basis. Multidisciplinary team (MDT) meetings are scheduled weekly.

We had previously made a recommendation in relation to the recording of MDT meetings. We were pleased to find that all of the MDT meeting notes we reviewed provided information on who attended, and a brief outline of decisions taken. We were told that work has been done around ensuring improved communication with families. Relatives and patients' views were sought and taken account of in the MDT meeting reviews. We found evidence of this in the notes and from our discussions with people. However, relatives or patients are not currently invited to MDT review meetings. We were pleased to see the progress so far in relation to this and look forward to hearing at our next visit how the involvement of individuals and their relatives in the MDT meetings and care decisions continues to be progressed.

Use of mental health and incapacity legislation

On the day of the visit, two people were detained under the Mental Health Act. 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. Neither of the patients who were detained required Consent to treatment certificates (T2) or certificates authorising treatment (T3) under the Mental Health Act.

Where individuals have granted a Power of Attorney (POA) or where there is a guardianship order under the Adults with Incapacity (Scotland) 2000 Act (the AWI Act), a copy of the powers granted should be held in the care file and the proxy decision maker should be consulted appropriately. We found that where there was a POA in place, this was recorded, and copies of the powers were available in the care files we reviewed. However, we did find one file where the individual was subject to a local authority guardianship; there was no record of this and no copy of the powers on file. On reviewing the admission documentation, it appeared that the existence of the guardianship was not included in the transfer summary from the previous placement.

Recommendation 1:

Managers should ensure that enquiries are made in relation to the existence of a proxy decision maker on admission, record this has happened, and have a copy of the powers held on file.

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. We found section 47 certificates in place for all patients that we reviewed and where staff were aware a proxy decision maker was appointed, they had been consulted.

For patients who had covert medication in place, the Commission's covert medication pathway was completed, and all appropriate documentation providing legal authority was in order.

Rights and restrictions

The ward doors were secured by a keypad entry system. Visitors exited and entered with the assistance of nursing staff. There was information about this on display. Person-centred visiting was supported, with core visiting times in the afternoon and in the evening, however, visits out with these times could be arranged. In the dementia unit, the communal day/dining facility was not accessed by visitors; visiting took place in each individual's bedroom or the small quiet sitting room.

The ward had access to advocacy, and details of the service were on display on several of the notice boards.

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

The ward had input from an occupational therapist and an occupational therapy assistant who provided a range of therapeutic and recreational activities on a one-to-one and group basis. The patient activity co-ordinator post was currently vacant, but interviews are scheduled, and it was hoped to have a replacement in post in the near future. The ward also had input from a physiotherapist who provided an exercise class and those who wish to attend are supported to use the gym in the Argyll Unit.

We saw patients participating in activities during our visit. Access to a range of face-to-face external supports has been re-introduced. We had previously made a recommendation in relation to the need to ensure activity care plans were person-centred. On this visit, we found activity care plans in the files we reviewed. These were person-centred and had been updated to include information on each individual's previous hobbies or activity preferences, which had been recorded in the care plan evaluations. We also found activity participation recorded in the chronological notes.

The physical environment

Ward 4 is on the first floor of the Larkfield Unit. There was a pleasant secure courtyard garden, however as this could not be accessed directly from the ward and could only be accessed with staff support. Staffing levels and clinical activity limit when this can be facilitated.

Bedrooms were a mixture of single en-suite rooms and small dormitories. The dining and sitting areas in 4B are separate and we were pleased to see that efforts had been made to make the mealtime experience pleasant with vases of flowers on the tables that were set for lunch.

In 4A, dementia-friendly signage is inconsistent with signage missing from some toilet doors, and coloured toilet seats not provided throughout. There is one large communal sitting, dining,

and activity area in 4A. This area can be noisy at times, which could be distressing for some individuals. The ward was clean, however the décor was rather drab and clinical, and several curtains were hanging off the rails. We also noted that hoists and other equipment were being stored in the bathroom area, making this cluttered and uninviting. We were told that redecoration and refurbishment, which had been delayed due to Covid-19 restrictions, will now be undertaken when the ward is decanted later in the summer. However, even with improved décor the ward is unlikely to fully meet the needs of the patient group due to the number of beds provided in dormitory accommodation and the ward not having direct access to a secure garden.

Recommendation 2:
Managers should ensure the provision of an environment that fully meets the complex needs of the patient group and supports the delivery of high-quality care.

Any other comments

We heard that the issues with personal laundry that we had been told about during our last visit had been resolved. However, there were issues with the supply of towels from the laundry, and this has led to several occasions where people had to delay having baths or showers as no towels were available for them. This is unacceptable.

Recommendation 3:
Managers should ensure an adequate supply of laundry to meet the needs of the ward and support care delivery.

Summary of recommendations

Recommendation 1:
Managers should ensure that enquiries are made in relation to the existence of a proxy decision maker on admission, record this has happened, and have a copy of the powers held on file.

Recommendation 2:
Managers should ensure the provision of an environment that fully meets the complex needs of the patient group and supports the delivery of high-quality care.

Recommendation 3:
Managers should ensure an adequate supply of laundry to meet the needs of the ward and support care delivery.

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 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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