Mental Welfare Commission for Scotland

Report on announced visit to: Langhill Clinic, Acute Assessment Unit (AAU), Inverclyde Royal Hospital, Larkfield Road, Greenock PA160XN

Date of visit: 10 March 2016

Where we visited

The Acute Assessment Unit (AAU) at the Langhill Clinic Inverclyde Hospital is a 20 bed acute in-patient psychiatric assessment unit for adults (aged 18-65 years) from the Inverclyde area. The ward is a mixed-sex facility with all patients accommodated in individual rooms; 18 of the 20 beds were occupied on the day of our visit. The layout of the ward generally allows for an area of female rooms and an area of male rooms. The primary function of the unit is to provide immediate emergency care and treatment and acute mental health care.

The Langhill Clinic comprises of an 8-bedded Intensive Psychiatric Care Unit (IPCU) and AAU which is an acute inpatient service; there is also an adult mental health day service. The Commission has recently visited the IPCU at Langhill Clinic so this visit was to the AAU only.

The AAU has now been operational for about three years and has replaced the adult acute mental health services previously provided at Ravenscraig Hospital. It is a purpose-built new building offering vastly improved conditions for patients in the Inverclyde area. This was the Commission's first visit to this new unit.

Our reason for visiting on this occasion was as part of our regular visits to acute adult wards and particularly to see this new service in operation.

As we have not previously visited this ward we chose to look at general issues important for patient care:

- Care, treatment, support and participation
- Use of mental health and incapacity legislation
- Rights and restrictions
- Activity and occupation
- The physical environment

Who we met with

We met with seven patients during our visit; there were no carers, relatives or friends present who wished to speak with us.

We also spoke with the senior charge nurse and several members of the nursing staff.

Commission visitors

Paul Noyes – Social Work Officer, visit co-ordinator

Mary Leroy – Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The patients we spoke to said that the nurses and staff were very good and they were generally happy with their care. Two of the detained patients were less happy about being in hospital but this was primarily due to the nature of their stay in hospital rather than the care they were receiving. During our interviews with patients we found they were able to discuss their treatment with us and generally seemed clear about future planning. All patients had a named nurse.

We also heard that the unit has been struggling to recruit a fourth consultant psychiatrist and there has been a succession of locums in post which has been difficult. There are ongoing efforts to recruit a permanent post.

There were no delayed discharges reported to us at the time of our visit. Staff said they had good links with social work but we heard that it can sometimes be difficult to find resources in the community to which patients can move. We were also told that a welfare officer visits the ward to help with benefit issues and other difficulties patients may have.

We saw good evidence of physical health needs having been addressed. We were also informed that there is good access to physiotherapy, to the dietician and other services that may be required by request. There is also pharmacy input. The fact that there is an adult mental health day service on-site that can be used by in-patients is a very helpful resource for patients

A psychologist provides three sessions a week to patients on the ward which can be accessed by referral.

Many of the patients we spoke to had used advocacy and we were informed that the ward has good advocacy input from The Advocacy Agency.

Patients said they had a good level of contact with their doctors and felt involved in their care. There was evidence of regular multidisciplinary team (MDT) meetings but progress and decisions were poorly recorded; it was not always clear as to the date of the meeting, who was there and the degree of patient involvement. This recording needs to be improved.

The patient notes we looked at had initial care plans but these were not individualised and they did not appear to address the patient's specific needs. There was little evidence of patient involvement in their care in their notes; we also found the quality of risk assessments variable. Our impression was that the quality of recording did not reflect the good care and input that we evidenced from speaking to patients.

Recommendation 1:

Managers should ensure improvements are made to MDT recording in-patient records.

Recommendation 2:

Managers should ensure that care plans address the specific needs of individual patients and are reviewed to reflect any changes in care needs.

Recommendation 3:

Managers should ensure patients' participation in care planning is evidenced in patient records.

Use of mental health and incapacity legislation

We particularly focused on seeing patients who were detained. On the day of our visit six patients on the ward were detained under Mental Health (Care and Treatment) (Scotland) Act 2003 provisions; we managed to speak with four of these patients. We found Mental Health Act paperwork easily in the notes of the individuals who were detained. We also established that all the detained patients had 'consent to treatment' (T2) forms and 'certificate authorising treatment' (T3) forms as required.

One of the detained patients we spoke was also subject to enhanced observation for personal safety reasons; this patient was complimentary about the way their care had been managed and felt safe in hospital.

All of the patients we interviewed were clear about their status, as were the staff. The detained patients had access to advocacy and were aware of their rights of appeal; the informal patients we spoke to were aware they could leave the ward if they wished.

Rights and restrictions

The AAU had a mix of informal and detained patients. The door to the ward was not locked and patients who were not detained were able to come and go freely from the ward. There was easy access from the ward to an open but enclosed garden area giving patients free access to outside space.

Activity and occupation

The ward had a good range of activities on offer for patients and the occupational therapists (OT) run a weekly activity programme. The ward has the use of a minibus which is well used. In addition to activity provision from the OTs there is an art group run by an art therapist and the nurses are involved in some activity provision, particularly during evenings and weekends. Good use is also made of the day hospital which is in the same building and the ward has access to their programmes.

Patients we saw spoke of being involved in a variety of activities and interventions such as relaxation, art group, anxiety management, holistic therapy, pampering sessions and a range of social outings.

The physical environment

The ward is part of a fairly new purpose-built clinic which has now been operational for about three years. The unit has 20 individual rooms which have en-suite facilities, rooms are spacious and bright and patients we spoke to seemed very happy with the accommodation provided. The ward also has plenty of communal space with quiet areas and the facility of a female-only sitting room which is also used when children are visiting the ward. There is a large dining room an activity room and direct access to a large and very pleasant enclosed garden which is well used by patients. We found the ward to be quiet and calm which the design contributes to.

Any other comments

We were made aware that due to pressures in other areas of the health board there are often situations where a small number of patients are accommodated in the Inverclyde AAU ward while awaiting a bed back on their local ward. It would seem that there are generally one or two patients at any one time in this situation. We spoke to one patient in such circumstances who confirmed it made visiting more difficult and there is a likelyhood that having built up a relationship with medical and nursing staff this is then disrupted by a move back to the home area. It is important to monitor this situation and be aware of the potential difficulties caused to patients and their families.

We were also informed that due to a considerable pressure on IPCU beds it can be very difficult to access IPCU beds when required. This can have an impact on patient care and safety and the Commission would wish to be alerted of specific concerns.

Summary of recommendations

Recommendations

1. Managers should ensure improvements are made to MDT recording in patient records.

2. Managers should ensure that care plans address the specific needs of individual patients and are reviewed to reflect any changes in care needs.

3. Managers should ensure patients' participation in care planning is evidenced in patient records.

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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