Mental Welfare Commission for Scotland

Report on announced visit to: Inverclyde Royal Hospital, Langhill Clinic, IPCU & Acute Assessment Unit, Larkfield Road, Greenock PA16 0XN

Date of visit: 29 May 2018

Where we visited

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 and the IPCU is an eight-bedded ward for patients requiring more intensive treatment and interventions.

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

We last visited these wards on 5 October 2017, and made recommendations regarding the need for improvements to recording in patient notes and the need for a ligature risk assessment on both wards.

Our main reason for visiting was as part of our regular visits to IPCUs and acute adult wards, and to follow up on our previous recommendations.

Who we met with

We met with and/or reviewed the care and treatment of 11 patients; four patients in the IPCU and seven patients in the AAU. There were no carers/relatives/friends present during our visit.

We also spoke with the charge nurses on both wards and the two advocacy workers who cover these wards.

Commission visitors

Paul Noyes, Social Work Officer and visit co-ordinator

Mary Hattie, Nursing Officer

Mike Diamond, Executive Director (Social Work)

What people told us and what we found

Care, treatment, support and participation

We heard from the charge nurses on both wards that the wards are generally running at full bed capacity nearly all of the time, and that any empty beds are usually utilised very quickly. Both wards has a full complement of patients on the day of our visit

AAU – At the start of our visit this ward had two empty beds, but these were quickly filled by waiting admissions. There was a mix of informal and patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the MHA), most patients were informal and four were detained. The length of time patients are spending on the AAU ward seems to be relatively short, generally weeks. There are good links with the

community teams and the Community Response Service (CRS) are helping patients move on from the ward fairly quickly.

IPCU – This ward was full with eight patients on the day of our visit; all of these patients were detained under the MHA. Three patients were requiring enhanced observation and of these, two patients were on one-to-one observation and one on two-to-one observation. We heard providing staff to cover for this level of observation is proving difficult and this is often made worse due to nurses being required to cover in other wards. Staff commented that, at times, they felt unsafe due to low staffing levels and we advised that any concerns staff have about safety should be raised with managers.

We heard that staffing of both the wards continues to be difficult. Despite attempts at recruiting staff there are still a significant number of vacancies; it seems to be proving difficult to attract staff to the area. There were no patients on the AAU ward requiring enhanced observation on the day of our visit, but we were informed that this ward also frequently has patients on enhanced observations which puts particular pressures on patient care. The particular impact of these staffing difficulties on patient care is the amount of time that can be spent directly with patients, and engagement in patient activity, especially for patients requiring to be escorted when off the ward. We heard there can also be an impact on completing paperwork for patient records.

We noted that both wards continue to have good input from occupational therapy (OT), with two OTs and an OT assistant leading on activity provision. Other services such as speech and language therapy, physiotherapy and psychology are by direct referral. Staff reported good access to pharmacy and patients reported good access to physical healthcare.

Though the OTs run a number of groups, we noted a lack of availability of any low level nurse-led psychological interventions which are likely to be of benefit to many patients. Such interventions in the past had been available at an adjoining day facility, but this is no longer available.

There was evidence of multidisciplinary team (MDT) meetings to discuss patient progress taking place regularly on both wards. We were pleased to see improvements to recording on the MDT record sheets, as this had been a recommendation from our last visit. We also noted improvements in care plans, which we found to be more person-centred and focussing on the specific needs of individual patients. Care plans were regularly reviewed and linked to MDT discussions.

Patients we saw spoke positively about their care and said they felt involved in their treatment. They also reported that the staff were generally helpful, and treated them respectfully. The only negative comments were in relation to night-time care, where several patients commented that they were discouraged from coming out of their rooms during the night and talking with staff.

Patients on both wards have good access to advocacy and we spoke with the two advocacy workers from Circles Advocacy who visit these wards. They said they have a good relationship with staff and patients on both wards and had no concerns to raise with us.

Use of mental health and incapacity legislation

For patients subject to detention under the MHA we found all the legal paperwork to be in order and accessible within patient care files.

We also established that all patients had consent to treatment certificates (T2) and certificate authorising treatment (T3) forms as required, so there were no issues in relation to compliance with medical treatment requirements of the MHA.

Rights and restrictions

The IPCU is a locked ward and as we would expect, all these patients were detained under either the MHA or the Criminal Procedure (Scotland) Act 1995.

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.

Detained patients were clear about their status, but we spoke to informal patients who were less sure of their status and what they could and could not do. The wards had no written information for patients or evidence of a formal induction protocol. We would encourage managers to use the Commission's Rights in Mind publication and supporting materials to improve this situation.

Recommendation 1:

Managers to undertake a review of their admissions process to ensure patients have written information regarding their stay on the ward, and know their rights as both informal and detained patients.

Activity and occupation

Patients and staff commented favourably on the input from the OTs. They run groups, including a walking group, breakfast group, relaxation, art activities, pampering sessions and a range of social outings. The OTs are also involved in individual work with patients as part of their care plans.

Patients reported a lack of activity in the evenings and at weekends, with nurses having little time to be able to run more informal activities. We heard the ward in the past had access to a minibus for outings which is no longer the case.

Several patients commented that there is exercise equipment in the clinic that is not able to be used by patients due to a lack of staff expertise and training to supervise

patients on this equipment. Exercise is an important element in patient recovery and we would ask managers to look at possibilities to improve this situation.

The physical environment

These wards are purpose built and patients have individual rooms with en-suite facilities. Rooms are spacious and bright, and patients we spoke to seemed very happy with the accommodation provided. The environment is unchanged from our previous visits.

AAU in particular has plenty of communal space with quiet areas, and there is the facility of a female only sitting room which is also used when children are visiting the ward.

The IPCU has pleasant patient bedrooms, but the internal space in the ward is less inviting and patients tend to spend a lot of time in their own rooms. The patient lounge area is the only space for activity on the ward.

Both wards have access to enclosed garden areas which are well used by patients.

A recommendation from our last visit was that managers undertake a ligature risk assessment of the wards; managers have informed us this has been completed.

Any other comments

Advance statements

We noted admission records now record if the patient does or does not have an advance statement, but very few patients seemed to have chosen to make advance statements.

We also saw no particular evidence that advance statements are being actively promoted on the ward; Commission guidance on advance statements is available to support this.

Televisions / TV reception

The issue of not being able to reliably watch television due to either broken equipment or poor reception was raised by several patients on both wards. This seems to be an issue of considerable frustration for patients who often have little else to occupy them, particularly at evenings and weekends.

Recommendation 2:

Managers should ensure that patients are able to watch television both on the wards and in their rooms.

Summary of recommendations

1. Managers to undertake a review of their admissions process to ensure patients have written information regarding their stay on the ward, and know their rights as both informal and detained patients.

2. Managers should ensure that patients are able to watch television both on the wards and in their rooms.

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.

Mike Diamond
Executive Director (social work)

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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