

Mental Welfare Commission for Scotland

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

Date of visit: 22 March 2017

Where we visited

We visited the intensive psychiatric care unit (IPCU) at Inverclyde Hospital. This is an eight bed unit for patients mainly from the Renfrewshire and Inverclyde area (aged 16-64 years) requiring intensive treatment and intervention. The ward is a mixed sex facility with patients accommodated in individual ensuite rooms. On the day of our visit there were six male and two female patients; all eight of the beds were occupied. Staff provide care for all major mental illnesses and generally manage acute crisis for the purpose of stabilisation of mental health. The aim is to stabilise patients mental health enough to be able to return to a less restrictive or appropriate environment.

Patients admitted to an IPCU would ordinarily be detained under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995, though there can be occasional informal admissions. All patients on the ward at the time of our visit were detained patients.

We last visited this service on 22 June 2015 as part of our themed visit programme to IPCUs. There were no specific recommendations from the last visit but on the day of this visit we wanted to pick up on issues raised from the Commission's visit and monitoring report 'Intensive Psychiatric Care in Scotland 2015'.

Who we met with

We met with five patients who had either asked to speak with us prior to the visit or agreed to speak with us on the day; we also reviewed their notes. There were no carers, relatives or families present during our visit or who asked to speak with us.

We also spoke with the ward manager, members of nursing staff and the consultant psychiatrist who is responsible for most of the patients on the ward.

Commission visitors

Paul Noyes, Social Work Officer and visit co-ordinator

Jamie Aarons, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The patients we saw generally spoke favourably about their care on the ward but several patients we met were particularly unwell and were less able to express an opinion regarding their care. There were only eight patients on this ward and several had been on the ward for several months or longer, so staff were very familiar with the needs of their patients.

Due to high levels of need two patients were on enhanced observation at the time of our visit with one on two to one observation and another on one to one observation which was placing considerable demands on nursing staff.

We noted good care plans in patients' records that were personalised and regularly reviewed along with comprehensive assessments of risk. One patient had particular choking risks and there was a comprehensive multidisciplinary care plan in place to manage physical as well as mental health needs.

We saw good evidence of regular multidisciplinary team (MDT) meetings to discuss care and treatment, with some patients with complex needs being managed under the Care Programme Approach (CPA), which is good practice. The MDT meetings were mainly attended by medical and nursing staff with representation from occupational therapy (OT), pharmacy and social work as required; access to psychology is on a referral basis. Patients we spoke to, generally said they felt included in their treatment and care planning.

There was also good recording of contact with relatives but we were informed that many of the patients on the ward did not have relative contact.

Staff informed us that advocacy is provided by 'Circles Advocacy' and is readily available to patients on the ward on a very much as required basis; no members of advocacy staff were present on the day of our visit.

The main issue of concern expressed to us during the visit was the difficulty in moving patients on from the ward. Patients can get 'stuck' in the unit due to a lack of other longer term specialist facilities to move on to; it can also be difficult to move patients back to acute wards due to pressure on beds and moves can often involve complicated exchange situations between acute wards and the IPCU. The issue of patients being able to move on from the IPCU ward was an issue raised at our last visit.

We were made aware of two patients whose discharge had been significantly delayed. The Commission has asked to be kept informed about the progress of these patients and of any resource issues regarding moving on. It was acknowledged that there were complex care needs in these situations and the patients were requiring and receiving intensive support.

Recommendation 1:

Managers should establish a mechanism to record and report delays in transfer from the unit for patients needing alternative care.

Use of mental health and incapacity legislation

All patients on the ward at the time of our visit were detained patients which is consistent with the nature of the IPCU facility.

We found Mental Health Act paperwork easily in the notes of the individuals who were detained. We also established that all the patients we saw had T2 forms and T3 forms as required, so there were no issues in relation to Compliance with medical treatment requirements of the Mental Health Act.

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.

Rights and restrictions

The IPCU is a locked ward but many of the patients had agreed plans allowing for short spells of suspension of their detention to allow them to leave the ward. Patients generally required to be escorted by staff when away from the unit which in many cases very much limited the amount of time available to them to leave the ward.

Patients were detained and understood the situation, but this lack of being able to leave the ward is an important factor in patients being able to return to more open wards as soon as possible.

There is no specific use of seclusion but distressed patients may be managed under observation in their rooms.

Activity and occupation

Several patients mentioned being bored on the ward and staff said it can be difficult to motivate some of the patients in relation to activity. There is an occupational therapist for the ward on two to three days each week and also nursing staff are involved in activity. There is little 'on site' for patients to do so activity is usually in the form of visits to the shops, outings or home visits.

Staff said, and we also observed, that patients tend to spend a lot of time in their own rooms with not much interaction between patients. There is a lounge area and an activity room that is shared with the admission ward. Most activity is generally on a one to one basis. We noted an exercise bike had been brought onto the ward for one patient who had asked to use it, but generally it has been difficult to engage patients in exercise.

The physical environment

Though the ward is relatively new and has ensuite rooms it is very small. Patient bedrooms are of a reasonable size and are bright, however, the internal space in the ward is less inviting and patients tend to spend a lot of time in their own rooms. Given the small number of patients and the fact that many of them are very unwell, any group activity is difficult. There is also really only the patient lounge area for any activity space on the ward.

There is a garden area which is a pleasant space but access to this garden is limited as staff supervision is needed when patients are in the garden. The garden fences are fairly low and any patient wishing to do so could relatively easily get out. There are also concerns that things could easily be brought into the ward to compromise patient safety.

Though not an easy task, it is important to look at ways the security of the garden area could be improved to allow better access for patients to spend more time outside if they wish; the purchase of outdoor exercise equipment may encourage activity as has been done in other IPCUs in the same health board.

Any other comments

Use of advance statements

We saw no evidence that advance statements were being actively promoted on the ward and it was not always clear if patients had an advance statement from their notes.

Recommendation 2:

Managers should ensure staff identify on admission if the patient does or does not have an advance statement and make sure it is available and highlighted in the care file.

Summary of recommendations

Recommendations

1. Managers should establish a mechanism to record and report delays in transfer from the unit for patients needing alternative care.
2. Managers should ensure staff identify on admission if the patient does or does not have an advance statement and make sure it is available and highlighted in the care file.

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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