Mental Welfare Commission for Scotland

Report on announced visit to:
Inverclyde Royal Hospital, Acute Adult Assessment Unit and Intensive Psychiatric Care Unit, Langhill Clinic, Larkfield Road, Greenock, PA16 0X

Date of visit: 10 December 2024

Where we visited

Langhill Clinic comprises of an eight-bedded intensive psychiatric care unit (IPCU) and a 16-bedded acute adult assessment unit (AAU). The service provides care and treatment for individuals who live in the Inverclyde area.

On the day of our visit, there were eight people in IPCU and 16 people in AAU, with no vacant beds.

We last visited this service in January 2024 on an announced visit and made recommendations in relation to secure storage of care plans, authorisation of medical treatment and providing a reasoned opinion where someone is made a specified person. Further recommendations were also made specifically to the IPCU in relation to person-centred care planning, the provision of recreational space and improved access to occupational therapy (OT).

The response we received from the service was that all care records are now stored electronically, with auditing carried out in relation to care planning, consent to medical treatment and specified person documentation. We were pleased to hear that a feasibility study is planned for IPCU to ensure available funding will maximise and improve recreational space.

We were also advised that the provision of OT has increased and plans are progressing across the multidisciplinary team (MDT) to improve choice of activities for individuals in IPCU.

On the day of this visit, we wanted to follow up on the previous recommendations and look at any other issues that may have had an impact on care and treatment.

Who we met with

We met with, and reviewed the care of 14 people, and we reviewed the care notes of a further three people. We also met with two relatives.

We spoke with the service manager (SM), the senior charge nurses (SCN), the consultant psychiatrist (CP), the occupational therapist (OT), student nurses and advocacy services.

Commission visitors

Gemma Maguire, social work officer

Anne Craig, social work officer

Justin McNichol, social work officer

Mary Hattie, nursing officer

Graham Morgan, engagement and participation officer

What people told us and what we found

We heard from those that we spoke with that staff are the 'best' and that 'nothing is too much' for them.

One relative we met with told us that their loved one received 'excellent' care, although we heard from another relative that communication from staff could have been better when their family member was first admitted to AAU.

We heard from the SCN that the service is looking to improve written communication with individuals and families when someone is admitted to the ward. We were pleased to hear that the service is reviewing admission packs and using 'you said, we did' to gather meaningful feedback from individuals and families.

We were also advised that Commission guidance is being considered to improve the written information provided to individuals and their families.

Many of the individuals we met with were aware of their rights, had access to legal advice and were either involved with advocacy or knew how to access this service.

At the time of our last visit to the service, we were impressed with the input that individuals and staff had from a dedicated psychologist, however at that time we were advised that funding for the post was due to end. During this visit we were pleased to find that funding for a dedicated psychologist has been continued. The post was vacant at the time of this visit although the SM confirmed that recruitment plans are progressing. We were advised by SCN's that the psychology service provides an 'invaluable' trauma informed and recovery-based approach to individuals.

On our last visit to the service, we met with one individual in IPCU who was assessed as requiring inpatient rehabilitation and recovery. At that time, we were advised transfer to a rehabilitation service was being progressed. During this visit, we were concerned that the individual has remained in IPCU awaiting transfer to a rehabilitation and recovery service. We discussed with SCN on the day of our visit and were advised plans were progressing for the individual to transfer, but a lack of available beds across services has contributed to delay.

We were also advised by the SM that there is a lack of bed capacity across various inpatient mental health services in NHS Greater Glasgow and Clyde (NHSGGC), as well as nationally. We heard how managers have continued to have daily bed management meetings to discuss risks and prioritise resources. We will continue to follow up on this issue.

Care, treatment, support, and participation

All care records, including care plans, MDT records and risk assessments were accessible on the electronic recording system, EMIS.

At the time of our last visit, we made a recommendation regarding person-centred care planning and reviews in IPCU. We were disappointed to find that the quality of care plan recording, including information on progress towards individual goals, continued to be inconsistent in IPCU. On the day of our visit, we discussed these issues with the SCN for IPCU. We were advised that improvements had been made by the service through a care plan audit process, however recording has been adversely affected by the introduction of a new care plan template.

Recommendation 1:
Managers responsible for the IPCU should carry out an audit of nursing care plans and reviews to ensure they reflect progress towards individualised goals.

In AAU, we found care plans were of a good standard, with person-centred reviews being consistently carried out, although the care plans were not to the same high standard that we had found on our last visit to the service. The SCN for AAU also told us that the new care plan documentation did not support staff to evidence individual progress towards goals and that they were time consuming to complete.

When reviewing care plans, we also experienced difficulties accessing specific information and had to scroll through the document which took us considerable time to do. We were told that staff were required to upload a new document each time a care plan was updated and/or reviewed. We were also concerned that that the new document did not enable individuals to sign their care plans. We were disappointed that the new document has not supported the service in recording person-centred care plans.

We discussed these issues with SM on the day of our visit and were advised that managers are consulting with staff on the implementation of the new document and these issues have been escalated to senior managers.

Recommendation 2:
Senior managers responsible for the IPCU and AAU should ensure recording systems for person-centred care plans and reviews fully support practice.

The Commission has published a good practice guide on care plans[1]. 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.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

When reviewing the care records, we found that individuals had a risk assessment completed upon admission, however reviews of these documents were inconsistent. We discussed this with SCNs on the day of our visit and were advised that in line with policy for the service, risk assessment documents are only updated when there is a change in the level of risk. We were also advised that the quality of recording can be inconsistent due to the various members of the MDT who complete these documents.

We advised that clear recording of risk assessment and discussion in the MDT meeting, even where there was no change, would evidence that reviews were taking place. We also advised that an audit process should be implemented to ensure there was consistency in the quality of information being recorded.

Recommendation 3:
Managers responsible for the IPCU and AAU should carry out an audit of risk assessment documentation to ensure consistency of recording and review.

Multidisciplinary team (MDT)
MDT meetings continue to be held weekly in both units and consist of the consultant psychiatrist (CP) pharmacist, OT, patient activity coordinators (PAC) and the advance nurse practitioner. As mentioned, the psychology post is vacant and referrals for psychology are currently made to community services.

On the day of our visit to the service, we met with the CP for the IPCU who advised us that they also cover another IPCU in NHSGGC and currently, there is no junior doctor available to support the CP. AAU has input from two consultants who provide inpatient and outpatient care.

We were advised by the SM on the day of our visit that the AAU should have three inpatient consultants, however this is currently under review as the number of beds in the unit has been reduced in recent years. We were pleased to hear from those that we spoke with that they felt involved in meetings, with their views recorded in the minute of the meeting. Family members were regularly invited to meetings, and their views were also recorded.

At the time of our last visit to the service, we were advised that funding for a discharge coordinator post had been agreed. We were given an update that funding has been extended for a discharge coordination team, with a coordinator post and a social worker post currently being advertised; we look forward to hearing how this team progresses during future visits.

Use of mental health and incapacity legislation

On the day of the visit, eight people in IPCU and 11 people in AAU were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental

Health Act). All individuals detained under the Mental Health Act were aware of their rights. Several individuals had nominated a named person, were receiving legal advice and accessing advocacy services.

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. Consent to treatment certificates (T2) were in place where required and corresponded to the medication being prescribed.

For one individual in the IPCU, we found there had been significant delay in requesting an independent opinion from a designated medical practitioner (DMP). A DMP visit is a safeguard that is required before a certificate authorising treatment (T3) can be issued. We discussed this with SCN on the day of the visit and were advised that the CP had requested a DMP prior to our visit.

The SCN confirmed the person was advised of the delay in authorising their treatment and provided with information regarding their rights.

Recommendation 4:
Managers responsible for the IPCU should ensure that reviews and audits of medication records for individuals requiring certificates to authorise their treatment under the Mental Health Act are carried out and findings are acted upon in a timely way.

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 accessible documentation and the named person had been appropriately consulted.

For those people that were under the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) we found documentation, such as copies of power of attorney (POA) certificates, to be accessible with details of granted powers, and the views of the attorney clearly recorded in the care records.

On the day of our visit we noted that the term 'AWI' was often used to refer to different sections of the AWI Act, such as management of patient's funds. To prevent confusion, the Commission would advise that all relevant sections of the AWI Act are specifically recorded. We discussed this with SCNs on the day of our visit who advised us that our advice would be incorporated into auditing processes. We were also advised that staff are aware of the NHS Education/Commission online learning resources in relation to AWI Act and that further training has been scheduled for staff.

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. For the individuals we reviewed who were subject to a section 47 certificate, we found these to be in place.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provides 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.

On the day of our visit two individuals in AAU, and four people in IPCU were specified under the Mental Health Act.

We reviewed the care records of these individuals and found that a reasoned opinion was not recorded when decisions were made to impose restrictions. We also found that individuals were not provided with written information regarding restrictions, including information about review and their rights.

For one individual in AAU, we were pleased to hear that the SCN had provided them with the Commission's guidance in relation to being a specified person, and had escalated a request for written information to be provided by a CP.

Recommendation 5:
Medical staff responsible for the AAU and IPCU should ensure a reasoned opinion is provided for all restrictions applied to individuals specified under the Mental Health Act.

Recommendation 6:
When someone is made a specified person, medical staff should provide individuals with written information regarding restrictions imposed, timescales for review and information about their rights.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[2].

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 found two copies in files and

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

information on writing an advance statement is provided by ward staff and supported by advocacy services.

The Commission has developed *Rights in Mind.*[3] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

Group-based and one-to-one activities in AAU continued to be supported by the PAC and OT services. Activities include relaxation groups, access to the gym and art groups.

During our previous visits to the IPCU, we had made recommendations in relation to a lack of OT provision. We are pleased to report that the OT service have recruited a Band 5 post which has eased pressure on this service. We met with OT who told us plans are now being progressed to increase OT provision in the IPCU from one half day to three half days, plus two breakfast sessions per week.

The SM also advised us that an additional PAC resource from the AAU will support activities in IPCU. We were updated by OT and SCNs that where the MDT has undertaken appropriate assessment, individuals in IPCU can access group-based activities in the AAU. We heard how this has improved access to activity and occupation for some individuals in IPCU as well as supporting their recovery when transitioning from the IPCU to AAU.

We are also pleased to hear that OT and PAC services continued to carry out functional assessments to prepare individuals for discharge and develop links with community-based services.

Whilst there was a motivated and committed staff team to engage people in activities, we heard from one individual in the AAU that weekends feel 'worse' due to having less things to do. We discussed this with SCNs on the day of our visit and were informed that PAC and/or OT services are not available at weekends in either ward. We were advised that activity provision is supported by nursing staff over weekends, which can be difficult due to managing other clinical demands and/or resource issues.

Recommendation 7:
Managers should ensure that individuals have access to meaningful activity and occupation seven days per week.

[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

The physical environment

The AAU was spacious, bright, and welcoming with appropriate garden facilities for individuals to access. People we met with on the day of our visit raised no issues regarding the environment in and/or out with IPCU.

We have previously made recommendations regarding the lack of recreational space available for individuals and were pleased to have an update that a feasibility study is to be carried out in IPCU; the SM informed us that this will ensure available funding is used to maximise and improve the provision of recreational space. We will continue to follow up on this issue.

On the day of our visit, one individual we met with reported concerns regarding individuals smoking cigarettes on hospital grounds. The Commission are aware that the law has changed, and it is not lawful for anyone to smoke in hospital grounds in Scotland. We discussed this issue with SCNs on the day of our visit. We were informed that individuals are advised not to smoke on hospital grounds and despite nicotine replacement therapy (NRT) being available, some continue to smoke in the areas outside the wards.

SCNs confirmed the service does have policies in relation to hospital buildings being smoke-free but do not feel it is the responsibility of ward staff to enforce such policies. They also expressed concern that enforcing policies on individuals who experience acute symptoms of mental disorder and have a nicotine addiction could cause further distress.

The Commission are clear that smoking on hospital grounds is an offence, with individuals being at risk of penalty notices and fines. Whilst the Commission understands that individuals may experience difficulties in relation to nicotine withdrawal, we are aware that other inpatient services are enforcing smoking bans and utilised NRT. We advised the SCNs to escalate their concerns to managers, and to consult with other services who are adhering to policies so that the AAU and IPCU can apply the further advice and learning.

Recommendation 8:
Managers of the IPCU and AAU should ensure that legislation and local procedures are adhered to in relation hospitals buildings being smoke free.

Summary of recommendations

Recommendation 1:
Managers responsible for the IPCU should carry out an audit of nursing care plans and reviews to ensure they reflect progress towards individualised goals.

Recommendation 2:
Senior managers responsible for the IPCU and AAU should ensure recording systems, for person-centred care plans and reviews, fully support practice.

Recommendation 3:
Managers responsible for the IPCU and AAU should carry out an audit of risk assessment documentation to ensure consistency of recording and review.

Recommendation 4:
Managers responsible for the IPCU should ensure that reviews and audits of medication records for individuals requiring certificates to authorise their treatment under the Mental Health Act are carried out and findings are acted upon in a timely way.

Recommendation 5:
Medical staff responsible for the AAU and IPCU should ensure a reasoned opinion is provided for all restrictions applied to individuals specified under the Mental Health Act.

Recommendation 6:
When someone is made a specified person, medical staff should provide individuals with written information regarding restrictions imposed, timescales for review and information about their rights.

Recommendation 7:
Managers should ensure that individuals have access to meaningful activity and occupation seven days per week.

Recommendation 8:
Managers for the IPCU and AAU should ensure that legislation and local procedures are adhered to in relation hospitals buildings being smoke free.

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 an individual's care, treatment, and support are 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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