Mental Welfare Commission for Scotland

Report on announced visit to:
Willow and Oak Wards, Orchard View, Inverclyde Royal Hospital, Larkfield Road, Greenock PA16 OPG

Date of visit: 28 May 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Oak Ward is situated in Orchard View on the Inverclyde Royal Hospital site. It provides care for 12 adults with complex care needs.

Willow Ward is housed in the same unit and is a 30-bedded ward that provides assessment and treatment for older adults who have complex care needs.

Both wards serve the Inverclyde local authority catchment area. On the day of our visit Oak Ward had seven patients, with five beds currently closed due to ongoing renovation work, which is due to complete in the next two weeks. Willow Ward had 22 patients, two of whom were transferred over from Oak Ward on a temporary basis.

We last visited this service in April 2023 on an announced visit and made recommendations on physiotherapy input, care planning, audit, and authorisation of medication under part 16 of the Mental Health Act. The response we received from the service was that there was ongoing action to address the issues.

On the day of this visit, we wanted to follow up on the previous recommendations and look at communication with carers and proxies.

Who we met with

We met with, and reviewed the care of 13 people, ten of whom we met with in person and three who we reviewed the care notes of. We also met with two relatives.

We spoke with the service manager, the senior charge nurse (SCN), charge nurses and members of the nursing team. We also met with the advance nurse practitioner, the activity co-ordinator, the lead occupational therapist, the advocacy service and one of the consultant psychiatrists.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

Gemma Maguire, social work officer

Catriona Neil, ST6 LD Trainee

What people told us and what we found

Relatives that we spoke with were positive about both the care and communication from staff. We were told “staff are amazing I have no complaints” and “I get enough information any time I visit or phone, nurses also phone me if there are changes to meds etc”.

We were also told “I haven’t been asked to attend MDT but don’t feel I need to as I get information from staff” and “I trust the staff to know the right thing to do and they tell me what I need to know”.

We heard from individuals that “I like the staff here and trust them”; “Everything is going well, the staff are helpful and it’s a nice environment, and “the consultant is lovely”, “staff are fine, and I am happy to be here”.

Advocacy told us that staff actively encourage involvement of their service, both for people subject to detention and those who are informal. We heard that referrals are appropriate and communication has been good.

We heard from nursing staff about the increasing levels of physical frailty amongst patients being admitted to Willow Ward and the impact that this has on the level of clinical activity and the nursing workload.

Care, treatment, support, and participation

Care records

Information on individuals’ care and treatment was held in on the electronic record system, EMIS and the electronic medication management system, HEPMA. There were also paper files containing Power of Attorney (PoA) or guardianship documentation, section 47 certificates, and do not attempt cardiopulmonary resuscitation forms (DNACPR).

On our previous visit, we made a recommendation about care planning. Care plans are now kept with the electronic record system, using a standardised template. There has been progress in this area, however further work is required in Willow Ward to ensure that care planning fully reflects all the current needs of the individual.

Care plans were person-centred. In Oak Ward, individuals were clearly involved in their care plans and there was family involvement recorded in care planning process in Willow Ward.

There were updated CRAFT risk assessments in all of the files we reviewed. In Willow Ward, there were completed ‘Getting To Know Me’ (GTKM) documents in most files. GTKM is a document that records information on individuals’ life story and their preferences that then informs care. However, the information contained in these documents did not always fully reflected what was noted in the care plans.

Care plans did not address individuals' activity preferences, nor did they provide information on the management of stress and distress.

We heard from the SCN that training on the management of stress and distress for all staff is underway and the SCN intends to introduce nurse-led care planning for stress and distress using the Newcastle model, which is a framework to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge.

Care plans were reviewed regularly, and reviews were detailed and meaningful, however care plans were not always updated to reflect the changes in needs or treatment that had been identified in reviews.

Recommendation 1:
Managers should undertake regular audits of the care plans to ensure these are person-centred and updated to accurately reflect all the patients' current needs and planned interventions, including management of stress and distress. Where necessary providing practice development nurse support to address any identified staff training needs in this area.

Where occupational therapy or physiotherapy staff were involved with individuals, we found discipline specific assessments and care plans setting out the goals and interventions, and sessions were recorded within the chronological notes.

Chronological notes in both wards were clear and relevant and included information on activity participation and carer/relative involvement. In the chronological notes, we found recordings of two incidents that had the potential for individual harm. It was not clear from the notes whether there had been a datix report or a referral made under Adult Support and Protection (Scotland) Act, 2007 (the ASP Act) to social work. Following discussion with the SCN and service manager it was confirmed that a datix had been completed on both occasions, however ASP referrals had not been made. It was agreed that for one incident a retrospective referral would be made.

Recommendation 2:
Mangers responsible for Willow Ward should ensure that local ASP Act procedures are followed when an incident occurs where there is actual or potential harm to vulnerable adults.

Recommendation 3:
Where serious incidents occur which require a datix report, managers on Willow Ward should ensure the number correlating to the report is clearly recorded in the relevant individuals care notes.

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.

Multidisciplinary team (MDT)
The wards have a multidisciplinary team (MDT) consisting of nursing staff, psychiatrists, occupational therapy staff, physiotherapy staff, a patient activity co-ordinator, and psychology staff. The wards also had input from the advanced nurse practitioner and a pharmacist. Referrals could be made to other allied health professionals and specialist teams, as required. Physiotherapy input had been increased following our previous visit recommendation, with more individuals now benefiting from this service.

There were four registered nurse vacancies on the wards; two staff were due to start and the remaining two posts were in the process of being interviewed for. There was one occupational therapist post that had just become vacant and this was out to advert.

MDT notes recorded a summary of the individual's presentation and progress, who had attended and the decisions made. In Oak Ward, patients and families were invited to attend the MDT meetings. In Willow Ward, patients and relatives were not routinely invited, however feedback on the outcome of MDTs was provided to relatives by telephone or during visits, and family meetings were held either at the request of the family or when consideration was being given to the need for ongoing NHS care. Family consultation and views were recorded in the chronological notes and care plans.

Use of mental health and incapacity legislation

On the day of the visit, six people in Oak Ward and eight people in Willow Ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All detention paperwork was on file.

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) and certificates authorising treatment (T3) under the Mental Health Act were in place where required. However, in Willow Ward we found three individuals were receiving treatment which was not authorised on their T3 certificate. We made a recommendation in relation to this on our previous visit in 2023 and repeat this again following this visit.

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

On the day of the visit, we met with the responsible medical officer for these patients, highlighted our concerns and provided guidance on the actions which they were required to take to rectify these issues.

Recommendation 4:
Medical staff should ensure that they are familiar with the Commission's guidance in relation to part 16 of the act and, where a T3 certificate is required, all medication prescribed is appropriately authorised on this**.**

Where an individual lacks capacity under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), a proxy decision maker can be appointed, either a guardian or power of attorney. This should be recorded in the individuals file along with a copy of the powers held and the proxy consulted in relation to decisions about care and treatment. We found one instance where the file stated there was no proxy decision maker, however on further investigation we found that there was a local authority guardianship in place. We asked that a copy of the powers be requested, and the file updated to reflect the individual status.

Recommendation 5:
Managers should ensure that enquiries are made on admission as to whether there is a guardianship or Power of Attorney in place. Where this is the case it should be recorded in the care plan and 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. It is also good practice to consult with the adult's carers or next of kin if there is no appointed proxy. We found s47 certificates in all the files we reviewed, where the individual lacked capacity. However, on one s47 form, consultation with the proxy was not recorded as staff had been unaware of the existence of the guardianship.

For those individuals who had covert medication in place, a completed covert medication pathway was in place, however it was not clear in some files if this had been reviewed in the timescales set out.

Recommendation 6:
Where covert medication pathways are in place these should be reviewed in line with the agreed timeframe and the review recorded.

The Commission has produced good practice guidance on the use of covert medication.[2]

Rights and restrictions

Commensurate with the level of risk identified in the patient group, the doors in Willow Ward are locked and entry was via a buzzer or key fob system. Information on this was provided to families and other visitors. Oak Ward operates an open door policy and during our visit several individuals informed staff of their wish to leave the ward and were allowed to do so.

The wards operate open visiting, with visitors welcome throughout the day and visits taking place in individuals' rooms and in visiting rooms and communal areas of the wards.

Posters providing information on visiting, advocacy services and local carers services were on display.

Sections 281 to 286 of the Mental Health Act provide 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. Where specified person restrictions were in place under the Mental Health Act, we found that there was a reasoned opinion, and necessary paperwork had been completed.

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

The patient activity co-ordinator has been in post for the past year and continues to develop in the role. They work across both Willow Ward and Ward 4 of the Larkfield unit, an older adult admission ward; they provide some input to Oak Ward.

We heard that this role has significantly enhanced activity provision and that there are regular outings to dementia cafés, local parks, and shops as well as several outings to the theatre. There is currently no formal structured activity programme; most activities are one-to-one or in small groups on an ad hoc basis, responding to the needs of the individuals at the time.

Occupational therapy staff undertake assessments and provide group and individual activity sessions in both wards. These can range from having a cup of tea and a

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

chat, to walks, relaxation groups, craft-based activities, cookery sessions, quizzes, and music sessions which are always popular.

Physiotherapy also lead gym sessions and walking groups.

We heard that Willow Ward staff are compiling playlists for life for some individuals. The wards also benefit from therapet visits.

We found activity participation recorded in the chronological notes we reviewed.

The physical environment

The wards have single en-suite bedrooms, with several communal sitting areas. The corridors are wide and bright, and the building has an open airy feel due to the large windows. There is a shared activity room and quiet visitors room off the main corridor.

Both wards have direct access to their own enclosed garden space as well as a larger garden area which surrounds the wards. Oak Ward was undergoing renovation at the time of our visit.

Willow Ward has a large bright main sitting area that opens onto an enclosed courtyard garden. There are several smaller sitting rooms available throughout the ward, although currently two of these are being used as storage while the renovations are underway in Oak Ward.

We heard of plans to create a sensory room in one of the smaller sitting rooms and staff are currently sourcing equipment for this. There is also an on-ward activity room with a TV, iPads and a selection of games and craft and activity equipment.

In Willow Ward there are memory boxes situated outside bedrooms, many of these are filled with personal items and pictures and some people have family pictures and personal items in their rooms.

In Willow Ward only a small number of bedrooms have TVs in them. We were told that over time as TV's have broken down, they have not been replaced. The SCN advised us she is looking to purchase several dementia-friendly radio sets for bedrooms, with the facility to upload individual playlists and with simple controls. In Willow Ward, several of the bedrooms we looked at did not have bed tables or individual chairs. In the main sitting and dining room we noted a cracked and damaged tabletop and seating was old-fashioned and tired.

We heard that due to the large windows the ward can become extremely hot, and it is difficult to regulate the temperature.

Recommendation 7:
Managers should review the furnishings in Willow Ward to ensure these are fit for purpose and there is adequate provision to meet the needs of the patient group and provide a pleasant environment.

Any other comments

Several staff raised concerns about the quality of meals that were provided. We heard that for individuals who required a soft diet they had no choice as there is only one soft option per meal.

On the day of the visit this was an omelette accompanied by piped potatoes. The meal was unappetising, the omelette was overcooked and very firm and the potatoes were not soft. We were told that staff were not allowed to order sandwiches or jacket potatoes for peoples' evening meal and were not able to order any additional sandwiches or snacks to have available for those who may miss a meal due to being asleep or distressed at mealtimes.

We heard that requests for additional squash had been refused by the kitchen resulting in this having to be purchased from ward funds.

Recommendation 8:
Managers should ensure that the meal provision is adequate to meet the needs of the patient group and that there is choice available at meals.

Summary of recommendations

Recommendation 1:
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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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