Mental Welfare Commission for Scotland

Report on announced visit to:
Inverclyde Royal Hospital, Wards 4 A and B, Larkfield Unit, Larkfield Road, Greenock, PA16 0XN

Date of visit: 14 August 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

Ward 4 is located on the first floor of the Larkfield Unit, which is part of a district general hospital. The unit has 20 beds for the assessment of older people and is designated as a short stay unit. The ward is divided into two sub-units; 4A has capacity for 10 beds for people with dementia and 4B has 10 beds for people with other mental illnesses.

On the day of our visit, there were 15 people across the wards. Bed numbers remain capped at 16 due to medical staffing issues.

The ward catchment area is co-terminus with Inverclyde local authority.

We last visited this service in April 2024 on an announced visit and made recommendations about the recording of proxy decision makers, laundry provision and environment. The response we received from the service was that all of our recommendations were acted on with the ward being refurbished.

On the day of this visit, we wanted to follow up on the previous recommendations and hear about any issues impacting on patient care and treatment.

Who we met with

We met with 10 people, and we reviewed the care notes of nine of those. We also met with two relatives.

We spoke with the service manager, senior charge nurse and the charge nurse. We also met with the clinical psychologist.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

Gemma Maguire, social work officer

What people told us and what we found

People we spoke with were generally positive about their experience, telling us some staff were helpful, and the charge nurse was “great”, although we did hear that at times there were not enough staff around. One relative told us that while they did not attend the multidisciplinary team meeting (MDT), they gave their views on a regular basis and felt listened to and kept informed of decisions. One lady who was being treated as an informal patient told us that when she has asked to go outside of the hospital environment for a cigarette, this has been refused. We discussed this and the implications of the non-smoking legislation with the charge nurse and service manager during our visit and asked that this situation be reviewed.

Care, treatment, support, and participation

Care records

Since our last visit, the ward has transitioned to electronic recording of care plans and the storage of paperwork for the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) on the EMIS system.

We found detailed risk assessments and comprehensive, person-centred care plans addressing both mental health and physical health needs in the files we reviewed. Involvement of proxy decision makers and family were reflected in the care plans. Care plan reviews were regular, meaningful and relevant. However, we found a few care plans that had not been updated to reflect changes identified in the reviews.

Recommendation 1:
Managers should audit care plans to ensure these are updated to reflect changes to care needs and circumstances identified in reviews.

We reviewed the files of several individuals who experienced stress and distress and were prescribed as required medication for this. In each case, there was psychology involvement and the use of Newcastle formulations had been completed or were being undertaken for these individuals. Where the Newcastle formulations had been completed, care plans for managing their stress and distress referenced this and contained information on triggers and management strategies to use with each individual. The Newcastle model is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge.

We found completed ‘Getting to Know Me’ (GTKM) forms in the files we reviewed and completed ‘What Matters to Me’ information beside each bed. Relevant life history information was documented either in initial assessments, or in Newcastle formulations where these were in place.

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 ward has regular input from psychiatry, psychology, and occupational therapy, with multidisciplinary team (MDT) meetings scheduled on a weekly basis.

We were told that due to staffing issues, there was no longer a pharmacy presence at MDTs and that pharmacy input had to be requested from Leverndale Hospital when this was required. This had an impact on the person's care and has resulted in delays in the completion of covert medication pathways. Other allied health professionals were available on a referral basis.

Of the MDT meeting notes that we reviewed, we found they provided information on who attended and a brief outline of decisions taken. We found that individuals and families/relatives' views were taken account of and recorded in the MDT meeting reviews; where relatives wished to attend reviews or meet with the consultant, this was facilitated.

Use of mental health and incapacity legislation

On the day of the visit, four people were detained under the Mental Health Act. All detention paperwork was on file and in order.

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. Where certificates authorising treatment (T3) under the Mental Health Act were required, this had been requested for one individual and a designated medical practitioner (DMP) visit had been arranged to complete this. For other individuals, these were in place and covered all medication.

Where individuals have granted a Power of Attorney (POA) or where there is a guardianship order under the Adults with Incapacity (Scotland)Act, 2000 (the AWI Act), a copy of the powers granted should be held in the care file and the proxy decision maker should be consulted appropriately. We found that proxies were being consulted appropriately and for all but one individual who had a POA in place, this was recorded and copies of the powers were available in the care files we reviewed.

Recommendation 2:
Managers should undertake regular audits to ensure that where there is a proxy decision maker copies of the powers are held on file.

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

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. We found section 47 certificates in place for all patients that we reviewed, and proxy decision makers had been consulted appropriately.

Several individuals were receiving covert medication. In the majority of cases the Commission's covert medication pathway was completed, and all appropriate documentation providing legal authority was in order. However, staff highlighted that one individual who recently commenced on covert medication did not have a completed pathway and we noted that another recently completed pathway did not have pharmacy involvement. In discussion with staff, we were advised that this is one of the impacts of the current absence of dedicated pharmacy input to the ward.

Recommendation 3:
Managers should ensure pharmacy input is provided at a level and in a timeframe to meet the ward needs.

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

Rights and restrictions

The ward doors were secured by a keypad entry system. There is a notice advising visitors to speak to staff when they wish to exit the ward. Some people we met with on Ward 4B were there on an informal basis, agreeing to admission, and wanted to remain in hospital. However, one individual who was informal, advised us they could not leave without staff permission and told us they were unaware of the door code to exit the ward. This was discussed with staff on the day, and we advised that should be reviewed with medical staff.

Recommendation 4
Managers and medical staff should ensure individuals who are informal are fully advised of their rights, and they should check that individuals understand their rights when being asked to consent to recommended treatment, including being advised not to leave the ward.

Person-centred visiting was supported, with core visiting times in the afternoon and in the evening; visits out with these times could be arranged. Relatives were asked to avoid visiting at mealtimes unless they were supporting their relative at mealtimes.

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

In the dementia unit, the communal day/dining facility was not accessed by visitors; visiting took place in individual's bedroom or the small quiet sitting room.

The ward had access to advocacy and details of the service were on display.

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 did not find any statements in the files we reviewed.

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 ward has input from an occupational therapist and an occupational therapy assistant who provided a range of therapeutic and recreational activities on a one-to-one and group basis. The activity co-ordinator post was vacant during our last visit; this has now been recruited to. The activities co-ordinator also provided a range of group and individual activities, including outings using the bookable hospital minibus. The ward had input from a physiotherapist who provided an exercise class and those who wish to attend were supported to use the gym in the Argyll unit.

We saw people participating in activities during our visit. We found information on individual's previous hobbies or activity preferences recorded in the care plans, along with evaluations and activity participation recorded in the chronological notes.

The physical environment

The wards are on the first floor of the Larkfield Unit. The wards have been refurbished since our last visit. The décor is bright, fresh and clean with new dementia-friendly signage and furniture provided throughout. As part of this work, a pinpoint alarm system has been installed.

In 4A, a wall has been erected between the activity area and the sitting dining area, creating a separate space and reducing noise transfer. There was also a small, quiet sitting room which was available for individuals who required a lower stimulus environment. There were murals in the dining area and activity area which brightened and added interest. We were told that the last few signs and pictures have still to be installed by estates.

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

The dining and sitting areas in 4B were separate. We were pleased to see tables in both dining areas set with tablecloths and flowers to make the mealtime experience pleasant.

Bedrooms remained a mixture of single en-suite rooms and small dormitories. There was a secure courtyard garden, however due to the ward location on the first-floor access to this required staff support and was therefore limited by staffing levels and clinical activity. Staff do endeavour to ensure that people have access to this facility.

Summary of recommendations

Recommendation 1:
Managers should audit care plans to ensure these are updated to reflect changes to care needs and circumstances identified in reviews.

Recommendation 2:
Managers should undertake regular audits to ensure that where there is a proxy decision maker copies of the powers are held on file.

Recommendation 3:
Managers should ensure pharmacy input is provided at a level and in a timeframe to meet the ward needs.

Recommendation 4
Managers and medical staff should ensure individuals who are informal are fully advised of their rights, and they should check individuals understand their rights when being asked to consent to recommended treatment, including being advised not to leave the ward.

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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