Mental Welfare Commission for Scotland

Report on unannounced visit to:
University Hospital Wishaw, Wards 1 and 2, 50 Netherton Street, Wishaw, ML2 0DP

Date of visit: 5 February 2026

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

Wards 1 and 2 in University Hospital Wishaw are 23-bedded, mixed-sex adult acute mental health admission wards. The wards are situated in the lower ground floor of the district general hospital and have access to enclosed garden areas.

On the day of our visit, there were 23 people on each of the wards/no vacant beds.

We last visited these services as a joint, unannounced visit in February 2022 and made recommendations on the re-establishment of the provision of activity co-coordinators for both wards. When we visited Ward 2 in February 2024, we again made the recommendation about an activity coordinator as well as a review of the laundry provision in Ward 2 so that there was no financial detriment to any individuals.

The received a response to the recommendation that set out the actions that were to be taken in relation to recruitment for a Band 3, Activity Co-ordinator and consideration that was being given to installing laundry provision in the mental health unit.

On the day of this visit, we wanted to follow up on the previous recommendations and actions.

Who we met with

We met with, and reviewed the care of 18 people, six of whom we met with in person and 12 of whom we reviewed the care notes only. We also met with one relative.

We spoke with the service manager, the senior charge nurses, the deputy associate nurse director, consultant psychiatrist, the advanced practice occupational therapist (OT), lead pharmacist, a healthcare support worker, student nurses, staff nurses, and a peer support worker.

Commission visitors

Alison Thomson, nursing officer

Anne Craig, social work officer

Margo Fyfe, senior manager

Gemma Maguire, social work officer

Laura Young, nursing officer

Mark Richards, nursing officer

Inez Kohls, student nurse

What people told us and what we found

Feedback from the individuals was positive about their stay in hospital. Most individuals told us they felt safe in the ward and that staff were nearby if needed and spoke positively about the clinical team who supported them. Both the wards had a welcoming atmosphere and we observed warm, respectful and supportive interactions between staff with individuals throughout our visit.

We could see that staff had a good knowledge of the individuals' needs and we heard from those that we spoke with that they spent time with the nurses on a one-to-one basis, which was either initiated by the individual or by the nurse. Individuals told us they felt involved in their care and were able to take part in the multidisciplinary team (MDT) meetings.

The only concern raised with us was that people were bored due to a lack of structured activities in the wards; this was raised by both staff and individuals. Staff spoke about how they have tried to mitigate the risk of not having an activity co-ordinator by allocating a member of staff on a day-by-day basis into the activity co-ordinator role. On the day of the visit, we heard from the service manager that NHS Lanarkshire are aiming to introduce band 3 activity co-ordinators in all mental health wards, and this has been escalated through the senior management team .

Care, treatment, support, and participation

We reviewed 18 individuals' files on the electronic recording system MORSE.

The care plans we reviewed were comprehensive and demonstrated a person-centred approach. It was evident that the care plans were regularly reviewed, and it was clear when progress had been made. The views of individuals were recorded in most of the records we accessed, although there were some where it could have been made clearer whose views were being documented. It was evident that engagement had taken place. The level of detail in the care records made it easy to identify what an individual's strengths and future wishes were.

We saw that risk assessments were completed appropriately, regularly reviewed, and highlighted relevant areas of risk. There was evidence of collaboration with individuals and carers in the risk assessment. The current risk assessments categorise risk with red, amber, and green coding. We were told NHS Lanarkshire are piloting a new risk assessment that moves away from categorising risk to be more in line with current evidence. It is being piloted in another clinical area with a view to being rolled out across NHS Lanarkshire. We look forward to hearing more about this when we next visit.

Individuals told us they were encouraged to participate in MDT reviews weekly. From the records we could see, the views of carers were also considered in these reviews, and carers were invited to attend the MDT reviews. The records highlighted that collaborative decisions were taken when changes in care were discussed at the meeting and were then communicated to the rest of the MDT and recorded as actions on MORSE, which made the progress and reviews of care plans clear.

There were changes to the way the MDT meetings took place in Ward 1 as a result of a new consultant psychiatrist taking up post; MDTs were taking place every day which then had an impact on other clinical activity. We were told that this was being trialled and will be reviewed over the coming months.

Care records
Use of the MORSE electronic recording system is now embedded in practice and we found information was easily accessible and accessible across different parts of the system.

The daily progress notes used a structured format which demonstrated the progress of an individual's care and treatment, including documentation about their mental state and how the individual had spent their day.

One-to-one sessions focussed on the person's wellbeing, understanding of their illness, and their stage of recovery. The one-to one sessions were recorded either as a stand-alone entry, or in the daily notes. We were advised these were regularly audited by the senior charge nurses in the wards.

Multidisciplinary team (MDT)
The MDT input to both of the wards consisted of medical staff, nursing staff, psychology, occupational therapists (OTs), pharmacy, and peer support workers. Social work staff and community mental health team staff attended the ward meetings as required, and advocacy services attended on a referral basis.

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and gave an update on their views. The meeting notes also included the views of individuals and their families/carers.

There were links between the MDT decisions and these being followed through in the care plans. It was noted that the provision of OT input had decreased due to absence and staff recognised that this had affected individuals; assessments were prioritised and ongoing work had to be deprioritised.

There were a number of individuals whose discharge from hospital was delayed. We could see that social work were involved and the senior charge nurse met with the delayed discharge coordinator on a monthly basis for an update on progress. We

were told that most of the longer delays were caused by a wait for accommodation or packages of care. On the day of our visit, the service manager highlighted that the model used by the wards sets a planned date of discharge, therefore discharge planning should commence at point of admission.

While we were visiting, there was input from an independent advocacy worker in Ward 1. All individuals that we spoke with knew about advocacy, and most had accessed the service. There were no posters in the ward to promote the advocacy service and when we raised this with the senior charge nurses, they advised us that they would rectify this.

Use of mental health and incapacity legislation

On the day of the visit, 27 individuals across Wards 1 and 2 wards were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act); three people were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

Some of the individuals we met with had a clear understanding of their legal status. One individual had altered communication needs and cognitive abilities; alternative means of communication were being explored.

All documentation relating to the Mental Health Act around capacity to consent to treatment was up to date and in place in the electronic and paper files. Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, 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 and corresponded to the medication being prescribed.

In Ward 1, we found that all T3s had been completed by the responsible medical officer to record non-consent, were up to date and available for staff to access. In Ward 2 on the day of our visit, there was a designated medical practitioner (DMP) in the ward attending to T3 requests.

We saw evidence of good practice with pharmacy's involvement in audit of the T2 and T3 certificates to ensure that prescriptions were in line with the legal authority to treat; results were fed back to responsible medical officers (RMO), service leads, and nursing staff with action points where required.

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. Individuals subject to AWI legislation require to have a section 47 certificate in place to authorise medical treatment, although this does not cover treatment under the Mental Health Act. There were three people who had s47 certificates in place.

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 and we would advise that staff encourage individuals to consider developing an advance statement at the earliest point in their admission.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person.

We discussed the use of advance statements and named persons notifications with staff and individuals. The staff in Wards 1 and 2 had a person-centred approach when discussing these options with people, finding a time when the individual would be able to decide about appointing a named person or writing an advance statement.

The discussion was recorded in the care plans and in MDT notes. Individuals told us that they were encouraged to think about named persons and advanced statements and knew how to access support for this.

There was one individual with an advanced statement in Ward 1 with a copy of their advanced statement that had been uploaded to MORSE.

Rights and restrictions

Wards 1 and 2 operate a locked door policy, commensurate with the level of risk identified with the patient group.

Access was by a buzzer entry system from the outside and individuals could leave the ward using the exit button at the inner door. The activity at the door was monitored by the nursing team at times of heightened risk. The individuals we spoke with told us they could leave the ward in line with their agreed time out, which was agreed at the weekly MDT. Some individuals said they would like to have longer time out but told us they were working to increase this that and could have escorted time out of the ward in addition to the agreed unescorted time.

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 the individuals were aware of this and of their rights in relation to reviewing this.

On the day of our visit, there were five people who were specified persons across both wards; all paperwork was accessible and in order. The individuals we spoke to with were aware of this restriction and had been provided with information about how to appeal decisions in relation to their specified status.

Two individuals were on continuous intervention in each ward at the start of our visit, although this was in the process of being reviewed and reduced for one person on the day of our visit. We noted that there were regular assessments, reviews and clear documentation around the rationale for continuous intervention for all individuals.

The Commission has developed *Rights in Mind.*[1] 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

On our previous visit, we recommended that managers should re-establish and progress the provision of activity co-ordinators in the wards. An action plan from the service manager in 2022 and 2024 confirmed that the workforce and skill mix was being reviewed to create dedicated Band 3 posts to undertake the role of activity co-ordinators. We heard that at this time, neither ward has a member of the team who undertakes this role, although we were informed progress had been made in escalating the case for these posts to the senior management team.

Recommendation 1:
Managers should ensure progress is made to re-establish the provision of activity co-ordinators in the wards.

At the time we visited the wards, staff were undertaking this role on an ad-hoc basis. While the senior staff team are keen to take this forward, this remains an ongoing recommendation. The Commission considers that this role would complement the existing work and activities undertaken by the peer support worker and the occupational therapists.

We noted that the individuals on the ward were supported to make the best use of the resources available and that staff had tried to provide meaningful activity. One health care support worker (HCSW) told us about how they promote and provide activities in the evening that encourages individuals to develop their community skills. The HCSW provided a rationale for the differing levels of support offered, depending on the stage each person was at. It was clear that individuals were

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

supported in a person-centred way to get the best out of their stay and remain as independent as possible and staff were available if the need arose.

There was evidence of regular activity in the ward, although from the staff and individuals' perspectives, this was not fully reflected in the notes. Activities were recorded, but not to the extent that was evident in comparison to what we heard from the individuals' and staff descriptions of what was taking place. We raised this at the end of day feedback and staff will consider how to rectify this. Staff and individuals were clear that the ad-hoc nature of activities were not sufficient and that an activity co-ordinator would enhance the experience in the wards.

Recommendation 2:
Managers should ensure that participation in activity is clearly recorded in the clinical notes.

The physical environment

The layout of both wards consisted of 11 single en-suite rooms with showers and there are three multi-occupancy rooms with four beds in each. In Ward 1, there was a separate bathroom area that was no longer in use and currently used as a storage room for various items of equipment and some individuals' belongings. As there is limited therapeutic space in Ward 1, there has been a request to remove the assisted bath and have this area re-purposed into a small meeting room to allow private space for meetings, such as one-to-one conversations or consultations with medical staff. This work has been proposed, and we look forward to seeing how this has progressed on our next visit.

The environment in both wards was clean and bright, and we were able to see where efforts had been made to soften corridors and public rooms with artwork and photographs on the walls

There was a communal lounge area in each ward which were in constant use and a quiet room for individuals to enjoy, with ambient lighting, soft seating (beanbags) and a bubble/light tube in Ward 2. The dining areas were large, bright, and welcoming. We were pleased to see leaflets on display and available to all who wished to know more about the various aspects of mental health.

Both wards benefitted from outside space for people to use. On our last visit, we noted that this area was overgrown and not particularly inviting, but we could see that this had significantly improved. The garden was now a clean, tidy, welcoming space where gardening groups were take place. Access to the garden was through the quiet room in Ward 2 and via a meeting room in Ward 1; this was not ideal, but there were no other alternatives that could provide access. We consider that it is important for people to have access to outdoor space, as fresh air is important for

wellbeing, particularly for those who cannot leave the ward to go to any other areas of the hospital.

Summary of recommendations

Recommendation 1:
Managers should ensure progress is made to re-establish the provision of activity co-ordinators in the ward.

Recommendation 2:
Managers should ensure clinical notes capture all relevant information, including participation in activity between individuals and staff.

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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