Mental Welfare Commission for Scotland

Report on unannounced visit to:
Gartnavel Royal Hospital, Intensive Psychiatric Care Unit (IPCU), 1055 Great Western Road, Glasgow, G12 0XH

Date of visit: 19 May 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

The Intensive Psychiatric Care Unit (IPCU) in Gartnavel Royal Hospital is a 12-bedded unit that provides care and treatment for individuals aged 18-65 years and who present with an increased level of clinical risk.

On the day of our visit, there were seven individuals on the ward and five vacant beds, although two of the bedrooms were out of commission.

We last visited this service in March 2025 on an unannounced visit and made recommendations about reviewing the audit process to improve person-centred care plans, individuals providing or refusing consent to care plans and adult support and protection paperwork being available and easily accessible on EMIS. Other recommendations related to training for staff on appropriate implementation of specified persons, improvement work being carried out to the de-escalation and extra care area and the white board in the office area being altered to ensure the confidentiality of the individuals in the ward.

We received an action plan from the service which advised that the first four recommendations had been completed; it gave details of how this had been achieved. The remaining two recommendations were in progress with details of how the service would progress to completion.

On the day of this visit, we wanted to follow up on the previous recommendations and look at any other areas that may have had an impact on care and treatment. We wanted to prioritise speaking with any individuals who wished to meet with us and any relatives or carers.

The Commission work with people who receive care and treatment, relatives / carers and professionals to produce guidance on best practice in complex areas of mental health and incapacity law. We were keen to look for any areas of good practice during our visit and highlight this.

Who we met with

As this was an unannounced visit there was not the same opportunity to make people aware of our visit to the service. On the day, we met with four individuals and reviewed the care notes of seven people. We did not speak with any relatives or carers. We spoke with the inpatient service manager (SM), the senior charge nurse (SCN) and one of the charge nurses (CN).

Commission visitors

Laura Young, nursing officer
Anne Craig, social work officer
Dr Sheena Jones, Consultant Psychiatrist

What people told us and what we found

The individuals that we met with shared their views on their contact with staff, access to activities and their care and treatment.

All the individuals we met with spoke positively about the staff involved in their care. We heard that nursing staff are 'brand new, decent and lovely' and that people found them to be 'transparent' and 'helpful'. Some individuals also spoke positively about their responsible medical officer (RMO) telling us that they 'got on well' with them and that their RMO gave them time to ask questions.

Staff that we spoke with knew the individuals in the ward well and understood the risks associated with their mental health. They were able to discuss individual's care and treatment in detail and were able to identify both individual needs and strengths.

The staff described the multidisciplinary team (MDT) working as "excellent" and that it had a clear focus on risk reduction and recovery; this was also evident from the files we reviewed.

Managers informed us that there were vacancies in nursing but there were plans to recruit; bank staff were being used to help manage deficits. We were advised the bank staff regularly worked in the ward and were familiar with the IPCU, the nursing team and individuals in the ward.

Care, treatment, support, and participation

Care Records

We reviewed care records in both electronic and paper format. The electronic patient record system used in NHS Greater Glasgow and Clyde (NHS GGC) is EMIS. The electronic prescribing and medication recording system used by NHS GGC is the hospital electronic prescribing and medicines administration (HEPMA).

Care plans, risk assessments, multidisciplinary review outcomes and daily progress notes were held on EMIS. Continuous intervention plans and personal safety plans were held on paper format.

We found the care records on EMIS to be organised, easy to navigate and provided the option for all professionals to record their clinical contact in the relevant sections of each individual's case record.

The paper files for each individual were largely systematic and information could be easily found.

Of the records we reviewed we found evidence of daily progress notes that provided an overview of the person and their day. Some were more detailed than others.

Care plans

A care plan outlines the care, treatment and interventions that an individual should receive, to ensure that they get the right care at the right time. It is a documented

record of needs, actions and responsibilities, which can be used and understood by individuals receiving care, their relatives/carers and others as appropriate.

Care plans were recorded on the NHS GGC standard person-centred care plan template. The standard template covered themes such as physical health, mental health, psychological therapies and social needs. If a person's care and support needs were not covered by one of those sections or related to several sections, it was not always clear where to record this, with different approaches being used by different staff members.

We raised this with staff on the day who agreed with this observation. Additional training and support had been sought from the practice development nurse (PDN), however challenges remain. We appreciated the staff's transparency on this matter.

Recommendation 1:
Managers should review the use of the standard person-centred care plan template to ensure that it supports person centred care planning.

We reviewed the care plans of all seven individuals who were in the IPCU at the time of our visit and found these to be inconsistent. There were a small number which demonstrated person centredness, however most lacked this.

Some were found to be nurse led and procedural; there were some which had information missing, such as an identified need; some had generic goals which lacked a recovery focus. There was one paper file which contained a historical care plan. We raised this on the day and were assured this would be removed. It is important that care plans are specific to the individual and not only capture needs but also strengths and can demonstrate the individual's involvement in the process. This should be a collaborative process that clearly evidences the person is at the centre of their care.

Reviews of the care plans were also found to be inconsistent. We found evidence of some which had regular reviews that were detailed. Others were found to have outdated information which lacked detail. This made it difficult to determine if all aspects of the care plan remained relevant, if the individual had been involved and whether any progress toward the care goal had been made. Care plans should be reviewed regularly, detail the frequency of the reviews and the reviews themselves should be detailed, person centred and where possible demonstrate the individual's involvement in the review.

There were two recommendations from our previous visit which related to care planning. One regarding review of audit processes to improve the recording of care plans to ensure these are consistently dated, person-centred and updated on one system to accurately reflect the patients' current needs and planned interventions.

We were pleased to see that generally, care plans were now stored on one system however it was disappointing that some care plans were still found to lack person centredness.

The other recommendation related to ensuring that individuals can actively participate in engaging or refusing to consent to care plans. We saw some examples of people's views being included in care plans and reference to people not wishing to be involved in their care plans. In other cases, the person's involvement and views on their care plans were less clear.

Recommendation 2:
Managers should ensure regular audit of nursing care plans and the review of these with a specific focus on quality, person centredness and individual involvement.

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.

We were pleased to see evidence of consent for involvement of a family member in an individual's care plan. We would hope to see this practice continue where consent has been given and is appropriate.

Risk assessments
We were pleased to see that all individual's files we reviewed had a risk assessment in place. In NHS Greater Glasgow and Clyde, the Clinical Risk Assessment Framework for Teams (CRAFT) is used. Of the records we reviewed, there was clear and relevant risk information documented in the CRAFT and these were up to date.

We were pleased to find individual personal safety plans in the paper files which were person centred and detailed.

Multidisciplinary team (MDT)
MDT meetings are held regularly in the IPCU and there is attendance and input from nursing, psychiatry and pharmacy. Individuals, their families and carers can attend the MDT meeting if they wish and attendance is recorded as part of the MDT record.

We found the MDT meeting records to be detailed and the records provided clear actions and outcomes. Physical health recording was good, and we found individualised and comprehensive records from psychology and occupational therapy.

Use of mental health and incapacity legislation

On the day of our visit, all individuals on the ward were subject to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) which is different

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

to our previous visit when there were a few individuals subject to the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act).

Documents relating to the Mental Health Act were easily accessible and available in the files we reviewed.

On the day of our visit, the individuals we spoke with were aware of their detained status and told us they were aware of their rights.

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. Medicines are prescribed electronically on HEPMA and paper copies of T2s and T3s are kept in a folder within the surgery where medication is dispensed.

Due to the timing of their admissions to the unit, there were only three individuals who were subject to authority to treat measures; all had a T3B in place. Two reflected what had been prescribed and were completed accurately. One had a discrepancy regarding a prescribed medication that was different from what was recorded on the T3B. This was raised on the day of the visit and followed up directly with the individual's RMO and has since been resolved.

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. Where an individual had nominated a named person, we found evidence of this in their file.

On the day of our visit we were informed there were no individuals under the Adults with Incapacity (Scotland) Act, 2000 (AWI Act). On reviewing the records, there was a 'pop up' indicating AWI for one individual but no documentation could be located relating to this. We raised this on the day; staff were unaware what this related to but planned to investigate.

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. On the day of our visit there were no individuals subject to this measure.

In our previous report, there had been a recommendation to ensure all paperwork relating to the Adult Support and Protection (Scotland) Act, 2007 (ASP) was recorded on EMIS and easily accessible to all staff. We had been informed that no individuals were subject to ASP and there was no records to review, therefore it is difficult to determine if progress has been made in this area. We will continue to monitor this on future visits.

Rights and restrictions

The IPCU has a locked door which would be expected for this type of environment and is proportionate, based on the clinical risk.

On the day of our visit there was one person who required care under continuous intervention (CI). The individual had a CI plan and the requirement for them to remain on continuous intervention was subject to regular review. There were no individuals in seclusion during our visit.

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 an individual 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 there were no individuals subject to specified person restrictions.

We were concerned on our previous visit that there was a lack of understanding from staff on the authority to restrict individuals' telephones and we made a recommendation to have staff training in relation to appropriate implementation of specified person. We followed this up on the day of our visit and were pleased to hear that the ward leadership team were ensuring staff were familiar with the use of specified person.

We were also pleased to hear that the ward had made changes to their practice regarding individual access to mobile phones. The SCN informed us that every individual now has access to their personal mobile phone unless there is clear rationale to indicate that this should be restricted and at that time, the person would be made a specified person.

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 copies on file for those individuals who had an advance statement.

Individuals we spoke with on the day of our visit were aware of the advocacy service and had access to legal representation.

The Commission has developed *Rights in Mind.*[2] 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.

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

Activity and occupation

On the day of our visit, we heard about the range of activities available which were viewed positively by the individuals we spoke with on the day.

Activities included pool, cards, quizzes, movie nights, the gym and accessing the hub and garden. We heard that individuals enjoyed the choice of activities and they liked that staff participated in them too, such as when the pool tournament takes place.

We were able to see that individuals had copies of the ward activity programme and on the day of our visit, staff and individuals were working together on a current theme for the ward.

We were informed there was a patient activity co-ordinator (PAC) who spent two mornings in the ward each week and there was also a music therapist who facilitated a session once a week. Input from both staff members was valued by the individuals we spoke with.

The physical environment

In general, the ward environment was found to be light and spacious. There are 12 en-suite bedrooms although two were out of commission on the day of our visit due to damage to the doors; work was already underway to repair these.

There is a communal day area, a small gym, a de-escalation space and two outdoor spaces. There are additional spaces for interview and activities.

We noted on the day of our visit that some of the chairs had material that was either cracked or torn, exposing the material beneath. We raised this with staff and were advised that furniture was being purchased for the services in the directorate.

Recommendation 3:
Senior managers should prioritise procurement of chairs for the IPCU ward.

On the day of our visit individuals were observed to be smoking cigarettes in one of the garden spaces. The service does have input from a smoking cessation service. The Commission is 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 staff on the day of our visit. We were informed that moving to a smoke free environment has been challenging.

The Commission are clear that smoking on hospital grounds is an offence, with individuals being at risk of penalty notices and fines. While 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.

Recommendation 4:
Managers should ensure that legislation and local procedures are adhered to in relation hospital buildings being smoke free.

It was highlighted on our previous visit that the temperature in the de-escalation space and extra care area was too cold; there was a subsequent recommendation regarding this. We were pleased to hear on the day of our visit that work had been carried out in these areas to improve the temperature in both spaces. None were in use on the day of our visit and we did not hear any issues from individuals we spoke with regarding this.

Summary of recommendations

Recommendation 1:
Managers should review the use of the standard person-centred care plan template to ensure that it supports person centred care planning.

Recommendation 2:
Managers should ensure regular audit of nursing care plans and the review of these with a specific focus on quality, person centredness and individual involvement.

Recommendation 3:
Senior managers should prioritise procurement of chairs for the IPCU ward.

Recommendation 4:
Managers should ensure that legislation and local procedures are adhered to in relation hospital 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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