Mental Welfare Commission for Scotland

Report on unannounced visit to:
University Hospital Wishaw General, Intensive Psychiatric Care Unit (IPCU), 50 Netherton Street, Wishaw, ML2 0DP

Date of visit: 26 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) is a six-bedded, mixed sex unit in University Hospital Wishaw.

An IPCU provides intensive treatment, support and interventions to individuals who present with an increased level of clinical risk and who require more intensive levels of observation. IPCU's usually have a higher ratio of staff to patients and a locked door. It would be expected that staff working in an IPCU have skills and experience in caring for acutely unwell, and often distressed individuals.

On the day of our visit, there were six people in the ward with no vacant beds. One person was on the waiting list for admission.

We last visited this service in October 2024 on an announced visit and made a recommendation on reviewing care plan documentation.

The response we received from the service was that they were starting monthly peer care plan audits, where they will highlight good practice and areas for improvement with an accompanying action plan. In addition to this, care assurance reports would be completed by the senior nurse.

On the day of this visit, we wanted to follow up on the previous recommendation, to hear about the IPCU network and how the process of accreditation from the Royal College of Psychiatrists Quality Accreditation Network was progressing.

We were advised that the service continues to move towards accreditation and that the IPCU was also involved with the Scottish Patient Safety Programme (SPSP) workstream on safety at points of transition.

The service is moving towards adopting the improving observation practice with the support of a team who have experience of working with this. We were told the senior charge nurse (SCN) and consultant psychiatrist are part of a national group looking at the use of mechanical restraints. We were also told that a new staff training matrix is being developed to enhance the skills of staff.

We were informed that NHS Lanarkshire is working on a new risk assessment, in line with best practice. The inphase incident recording system has recently been implemented which has functionality to allow clinical areas to run reports and review trends more readily than their previous system.

Who we met with

We met with, and reviewed the care of six people, two who we met with in person and four who we reviewed the care notes of.

We did not meet with any relatives as this was an unannounced visit and there were no relatives or carers available on the day.

We spoke with the service manager, the SCN, the senior nurse, the consultant psychologist, the lead pharmacist, the ST6 Doctor and the consultant psychiatrist.

In addition, we met with four trained nursing staff and two clinical support workers.

Commission visitors

Alison Thomson, nursing officer

Karen Beattie, nursing officer

What people told us and what we found

On the day of the visit, we spoke to two individuals who were positive about the IPCU staff stating, “the staff are great, I can talk to them”. One individual told us they felt involved in their care and felt the benefit of being in the ward.

Another individual told us they were included in all decisions about their care and felt involved. They told us they were invited to MDTs. Those that we spoke to were positive about their experiences in IPCU.

We saw staff interacting with individuals in a professional manner and at the pace the individual was comfortable with. Staff respected individuals’ preferences and boundaries.

Staff were knowledgeable about the individuals on the ward and had a comprehensive understanding of their physical and mental health.

Care, treatment, support, and participation

We heard from the SCN that they currently have one nursing vacancy, and one occupational therapy vacancy. The ward was well staffed and had staff team who were well versed in the requirements of an IPCU. When bank staff were utilised, it was usually the staff from the IPCU who pick up the additional shifts.

Several of the people on the ward at the time of our visit had complex physical healthcare needs in addition to their mental health needs. Staff had undertaken additional training to enable them to support those individuals in a safe, effective manner.

It was evident that other specialities such as speech and language therapies (SaLT), dietetics and other medical specialities liaised regularly with the IPCU team to optimise the care that was provided. Decisions about how best to care for individuals were reviewed regularly in line with their needs.

We noticed joint working between mental health and general health services while we were on our visit and this was evident throughout the clinical notes. We were pleased to see that there was an emphasis on including relatives and carers and strengthening the triangle of care. We were told about the support that was available to relatives and carers from psychology and clinical staff.

The IPCU is situated in the general hospital at Wishaw. This provided the opportunity to refer people to medical and surgical services as required and for colleagues to review people in IPCU, due to the availability of the medical emergency response team. This was particularly helpful when people were acutely physically unwell and was clearly of benefit to those in the IPCU.

We were told about the additional training staff had received which improved their skills in relation to any complex physical health needs of the individuals.

Care records

We noted that for one individual, they had been in the IPCU for an extended period of time. There was a comprehensive plan in place to support the individual's complex care needs in IPCU with a range of therapeutic interventions that supported ongoing contact with their family.

When we discussed care and treatment, it was evident that the team had a positive person-centred approach and were flexible in their approach to best meet the needs of those in the IPCU.

We reviewed the care plan documentation available on the electronic system, MORSE. Each person had care plans specific to their individual needs and we found the care plans to be clear, detailed, and up to date.

We were pleased to see that the recommendation in our previous visit had been acted upon and found that reviews of care plans were clearly documented, with discussions recorded about any changes that had been made. We found detailed physical health care plans with clear escalation plans in place and input from the relevant professionals.

In addition to care plans, we reviewed the daily continuation notes which were completed during the day and again at night. These summarised the person's mental state, any changes in their presentation, activities that they were offered and their ability to participate in them. The continuation notes were detailed, clear, and concise.

We saw that nursing staff also regularly recorded when they spent time with, or attempted to spend time with, a person on a one-to-one basis. The records noted what they did during that time; they gave an overview of the person's mental state and any goals they wished to discuss.

Risk assessment documentation for each individual was reviewed. The risk assessment and management plans were in the form of a traffic light system which contained detailed background information and information relating to historical and current risk.

Risks included mental health, physical health, and risk to self. For each person, an overall risk category was recorded, and this was revised over time. We noticed there was multiprofessional formulations included in the risk assessments and management plans, that these were discussed and reviewed at MDT meetings and at points of change for the individual. The addition of the formulation in the current risk assessment ensured there was a context around the traffic light system.

We are aware that NHS Lanarkshire is working towards a new Lanarkshire Safety Assessment Framework (LSAF) risk assessment, which in line with current guidance, will move away from the traffic light risk assessment.

Ward staff also complete an additional SBAR (Situation, Background, Assessment, Response, Review) form when a person is admitted and then on a weekly basis for each individual in the ward. This acted as a summary of the reason for admission and a way to record progress each week.

On our last visit we asked about the purpose of this form as it appeared to duplicate some of the information in the weekly multidisciplinary meeting minutes. Senior staff told us they have been considering whether the form continued to be required. We were told that staff find this weekly review useful and it is a helpful tool for when individuals move on.

Multidisciplinary team (MDT)
The IPCU has multidisciplinary input including psychiatry, psychology, occupational therapy, dietetics, and pharmacy. There is also an ST6 doctor. This IPCU has a lead pharmacist, a consultant clinical psychologist, and the clinical director as their consultant psychiatrist in the team.

The minutes from the weekly MDT meetings were reviewed in each individual's electronic care records. The minutes were detailed, specific; they noted any changes in presentation and what the plan of care was.

The legal status of individuals, consent to treat, medications, and mental and physical health needs were reviewed at the meetings. It was clear who had attended each meeting.

The involvement of individuals, relatives and carers and external professionals, such as local mental health teams and social workers, was documented.

In the electronic medication prescription system HEPMA, we saw pharmacy care plans for each person. Where people had physical health conditions that had an impact on their medical treatment, or where they were prescribed medications that required more intensive monitoring, we saw care plans to support this.

We heard about the psychology input to support individuals, their families, and staff. Psychology is embedded in IPCU and this is evident in the care plans, risk assessments, risk management plans, and the input into MDT reviews.

Use of mental health and incapacity legislation

On the day of the visit, six people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). One individual was under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

We found evidence that individuals were informed about their rights and this was recorded in the electronic care records; individuals had been assisted to access support in relation to their rights. There were posters about rights, advocacy, and mental health displayed in the unit.

We were told that people could access advocacy by referral and were provided with information about this by the ward team and by Mental Health Officers (MHOs). We saw evidence in the clinical notes of an individual having contact with advocacy.

The legal paperwork was held in a paper file in the office. This was readily accessible, easy to navigate, and up to date.

All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment were accessible and up to date.

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 and corresponded to the medication being prescribed.

The consent to treatment certificates were reviewed at the weekly MDT, and a copy was stored in the treatment room.

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 details of the named person on file and reference to their views in care plans. We noticed that the option to nominate a named person was revisited with individuals and documented in their notes.

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 those people that were under the AWI Act, we found alerts in the individual's notes and copies relating to this in the legal paperwork. We found section 47 certificates in place, with relevant discussions with the noted proxy decision maker.

Rights and restrictions

The unit operates a locked door policy which in keeping with the needs of the people receiving intensive treatment.

We saw comprehensive plans to support people to safely have time off the ward, including a person-centred plan to facilitate home visits for an individual with

complex physical and mental health needs. Individuals in the IPCU had access to a secure courtyard.

There were some individuals in the ward were on continuous intervention at the time of the visit; a clear rationale was in place for the level of support that was required. We noted that individuals were managed differently and this was done in line with their level of need and preferences. It was noted that where individuals required this more restrictive approach and that their distress was increased by this, due to limited privacy, it was managed in a way to mitigate the risk.

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 a reasoned opinion was recorded and the individual had been informed in writing. There was evidence in the clinical notes that individuals were informed of their rights in relation to a review.

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 on file for the six individuals in IPCU. We discussed this with staff who advised us that community teams have been exploring this with people in the community; we look forward to seeing any impact this might have on future admissions.

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

In previous visits we noted that there was a range of activities available to individuals, in line with their interests and abilities.

On this visit we were told about cooking groups, outings, and one to one activities. There was input from occupational therapists, psychology, and nursing staff. The individuals on the ward are assessed to determine their individual level of

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

engagement in whatever activities are appropriate and of interest, based on their ability and preferences.

There was access to table tennis, a large cupboard with many crafts and games, access to gym equipment, a TV and games consoles, as well as a quiet space and kitchen equipment.

We heard about work with families and individuals around relapse prevention and psychoeducation.

Staff were supporting an individual with complex physical and mental health needs to maintain contact with his family and local community in order to provide quality of life outings in difficult circumstances. It was noted that every effort was made to prioritise these visits in line with the individual's wishes and those of his close family.

The activities on offer were tailored to the needs of the individuals in the ward. We heard that there have been some admission for individuals with a learning disability; we were told about how activity was specifically designed to meet the needs of these individuals.

We are aware that NHS Lanarkshire are looking at activity provision more broadly and we look forward to seeing what improvements this may add to the comprehensive activities that are already on offer.

The physical environment

The IPCU is accessed by locked double doors through a locked reception area.

There is a family room in the reception area that was clean and bright, with a table and chairs. The ward has a main central corridor with office space, meeting rooms and dining and living areas along each side. The communal rooms are bright and clean with comfortable furniture.

There is access to a courtyard area which is well maintained. There is no smoking in the courtyard and individuals are supported with nicotine replacement therapy if required.

The bedroom area is at the end of the corridor. We saw one bedroom and it was furnished with items appropriate to an IPCU setting. There were several individuals with complex physical health conditions requiring additional equipment to support them. This was facilitated in their rooms and risk assessments were in place to reduce potential risk.

We were pleased to see the work on the ensuite doors mentioned in our previous report had been completed.

We saw posters for advocacy but were advised that these were frequently taken off the walls by an individual.

Any other comments

The unit continues to work towards quality network accreditation from the Royal College of Psychiatrists and are looking to apply for this next year. We also heard about the work with psychology to provide reflective practice and staff support.

Summary of recommendations

The Commission made no recommendations.

Service response to recommendations

Although no recommendations were made for this visit, the Commission would 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 and should be returned within three months of the publication date.

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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