Mental Welfare Commission for Scotland

Report on unannounced visit to:

Ward 3, University Hospital Wishaw, 50 Netherton Street, Wishaw, ML2 0DP

Date of visit: 6 June 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 3 is an admission and assessment ward for older adults with various mental illnesses, excluding dementia. It is a 23-bedded, mixed-sex unit in the mental health department of University Hospital Wishaw.

The ward provides care for individuals from Motherwell, Bellshill, Coatbridge, Airdrie, and the Wishaw area.

On the day of our visit, there were 19 people on the ward.

We last visited this service in May 2024 on an announced visit and made three recommendations. These recommendations were that nursing care plan reviews should be audited to ensure they reflect the person’s progress towards their care goals and there should be consistent recording of this across all care plans, that continuation notes should provide sufficient detail of the individual’s presentation, and interactions with those around them and of activities during the outgoing shift. There should also be regular audits of section 47 certificates to ensure that treatment plans were completed and up to date.

On this unannounced visit, we wanted to follow up on the previous recommendations, meet with individuals, relatives/carers, and staff to hear their views and experiences on how care and treatment was being provided on the ward.

Who we met with

We met with six individuals and reviewed the care of five of the people we met with, during our visit. We also spoke with three relatives.

We also spoke with the service manager (SM), the senior nurse (SN), the senior charge nurse (SCN), the charge nurse, (CN) nursing staff and the activity co-ordinator (AC).

Commission visitors

Sandra Rae, social work officer

Gordon McNellis, nursing officer

What people told us and what we found

We gathered feedback from individuals and relatives in relation to their care and their experience in the ward; this was mostly positive.

Individuals told us the staff in the ward were “excellent” that they “receive the best care”, that nurses were “great”, “brilliant” and “give me a sense of hope” and that “nothing was a bother.” We heard from an individual that staff “cared more about me than anyone else has ever done, and they are making sure I go to the right place, in a way that does not make me anxious”. Others said “the staff are all so good at listening and I can talk to them in private at any time”. We also heard “the doctor speaks to you every week to make sure you are doing alright and to talk about your plan”. We heard that staff “are good at supporting us to attend the groups in the ward and taking us out for coffee and lunch.”

Two people we spoke with said that they were bored and used to getting on with their lives at home and had found being in hospital difficult. We also heard mixed views about the food with some thinking it was “good” with others having the view that “it was not great and there was no variety”.

We heard that there could be “a lack of privacy when lots of visitors come to the ward as we are not allowed in our bedrooms”. We also heard that the garden was not open all of the time. When we asked more about this, we were informed that access to this was risk assessed and had to meet the needs of all the people on the ward. We heard that on occasion, people could be waiting for a while for information as staff could be busy however this happened rarely. The individuals we met with were able to tell us about their involvement in their care and treatment and about their recovery, while others told us about their involvement in their discharge planning.

We heard from families and carers who were mainly complementary of the whole staff team. We heard that “staff are second to none”, that “communication is exceptional”, that “all staff treated my family member with respect and dignity”, that “care delivery is 100%”, that “I know my relative receives great care and they tell me how good staff are to them, which is a great relief for me” and that “they listen to my views and invite me to attend meetings as well”. A relative told us that they “couldn’t fault the team and that the consultant took time to speak with them “when it is suitable for me as I work full time” , as well as “the nurses have been great and recognise me as a carer and the stress that can bring leaving my relative in hospital or worrying about their return home”. One family member said it was difficult because of their relative’s view; they did not feel they could interfere and ask nursing staff how their relative was doing, so felt conflicted and were not sure of the protocol or what their family member’s reaction would be to them asking too many questions.

We heard from student nurses and staff that the whole ethos from the senior managers creates a caring, nurturing culture for the people on the ward, but also for the staff team. We heard examples of this genuineness such as “the senior nurse knows all the individuals on the ward and their situation and cares for them in the same way we do.” Staff informed us they had enjoyed working on the ward; some staff had worked in the ward for many years and told us they were really satisfied working in the ward with a “great staff team”. We also heard how the management team also ensured that “when there are pressures in the ward, we are all supported, and our views are considered”. We heard that “our senior charge nurse advocates so well for us, the people on the ward and families.” We appreciated that this was important to the team due to the need for staff working with various levels of mental acuity and with the significant levels of stress and distress of people on the ward. We heard from students that this was a ward they would choose to work in as “it is a nurturing and caring ward from the top to the bottom - they all care for me.”

Care, treatment, support, and participation

Care records

All individual care records were stored on MORSE, the hospital electronic record system. There was also documentation, such as information around medical treatment stored in paper records in the treatment room and a small folder about the person, with information for quick reference, such as family and general practitioner contact details.

We found the records easy to navigate and the continuation notes contained robust information that linked to care plans. We found admission assessments were comprehensive and included a full physical health check for each person.

We found weekly one-to-one discussions between the named nurses and individuals in all the care records we looked at, which were meaningful and detailed. We also found therapeutic interventions recorded in detail to a high standard for each person. We heard from the individuals that we spoke with that “the staff are available to talk with anytime I want.”

Care plans

We saw care plans that were person-centred; they showed a strengths-based approach and focussed on recovery to support discharge. We found a wide range of care plans that were individualised and included the work of different disciplines. These gave good insight into the individual and documented the full range of care for mental health, physical health and wellbeing of each individual’s needs. The care plans, risk assessments and risk management plans all linked to both mental and physical health. These were thorough and reviewed regularly.

We noted that the multidisciplinary team (MDT) were fully involved in the care and treatment plans, which evidenced an integrated approach to care. We were pleased to see the individual’s participation was reflected in care plans. We also saw the persons relatives/carers input into care and treatment plans, by providing information and their views.

We were pleased to see that an earlier recommendation in relation to continuation notes providing details of individuals presentation and interaction with others had been met. We also heard there was ongoing monthly audits of care plans, with action plans that were shared with the team and promoted improvement, with robust care plans that supported each individual’s wellbeing on the ward.

Delayed discharge

Delayed discharge is a term used when a person is medically fit to leave hospital, however, is unable to leave due to non-medical factors. This usually means there is a lack of appropriate care or services available, such as a lack of available care home placement or difficulties in coordinating care. It can also be the result of there being no legal proxy in place which is needed to support the person’s move from hospital to a care setting if they are not in agreement with the move.

During our visit there were seven people who were recorded as being a delayed discharge. For five people, they were waiting for a care package to be put in place. For another person, they were waiting for specialist equipment to allow them to leave the ward and for another, a guardianship application was needed to allow discharge.

Multidisciplinary team (MDT)

The MDT had a wide range of professionals who contributed to the individuals care and treatment. This consisted of consultant psychiatrists, clinical staff, a pharmacist, nursing staff, an occupational therapist (OT), social work, advocacy and psychology. The delayed discharge nurse also attended the ward, and if appropriate, members of the community mental health team (CMHT). Staff told us that individuals had regular access to allied health professionals, such as dietetics and physiotherapy.

The MDT meetings were held over four days in the week. There were five consultant psychiatrists who each provided input to those on the ward, with each consultant covering a specific area. Each MDT meeting used a template to record meetings in a standardised way. We found a record of each person’s MDT meeting on MORSE.

To ensure the consistency of records of the MDT decisions, a member of staff was identified to attend each MDT meeting and to action any follow up that was needed. This member of staff was supernumerary to the staffing establishment for the ward on the day of the meetings.

It was clear from the detailed MDT meeting minutes that everyone involved in an individual's care and treatment was invited to attend their meeting and give an update on their views. The MDT meeting also included the person and their family, should they wish to attend. There were clear links between the MDT decisions that were then followed up in the care plans. It was clear to see from these notes when the person was moving towards discharge, and that community services also attended the meetings when relevant. It was also evident when someone's discharge was delayed, and a record of the actions being taken to help progress this.

Use of mental health and incapacity legislation

On the day of our visit, three of the 19 people in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 ('the Mental Health Act'). We found the documentation that related to the individual's legal status was in order and easily accessible.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) should correspond to the medication being prescribed.

All documentation relating to the Mental Health Act around capacity to consent to treatment was in place and completed appropriately. We asked the managers at the end-of-day feedback session whether they had a process in place for auditing T2 and T3 treatment certificates. They told us they did not, however were in the process of doing so. They informed that this would give a more refined ward process and reassurance for staff that they are administering medication as per the legislative framework.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment follows 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 that all section 47 certificates were completed appropriately, and they all had a treatment plan. We were pleased to see the recommendation from the Commission's previous visit, to regularly audit section 47 certificates which would ensure that treatment plans were completed and up to date, had been actioned.

There was no one who was subject to covert medication arrangements when we visited the ward.

Rights and restrictions

Ward 3 had a locked door, with the relevant policy in place, to provide a safe environment and to support the safety of the individuals on the ward. We were pleased to hear from those we spoke with that they were clear about their informal status and being able to leave the ward as they were not subject to restrictions. We saw evidence that the policy was reviewed regularly.

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. There were no specified persons during our visit.

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 were informed that there was one individual with a named persons and that their information had been recorded in Ward 3's documentation.

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. Although those in Ward 3 were unable to write their own advance statement, they could be supported to take part in an appropriate decision-making. We were informed that the consultant carrying out the assessment for detention and the mental health officer (MHO) discuss advanced statement and named person responsibilities with individuals admitted to the ward. We were informed that the ward staff also makes referrals to advocacy to support this process.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

Activity and occupation

Ward 3 has a designated activity coordinator who devises a weekly activity timetable, which includes input from individuals on the ward, to identify and focus on individuals' preferences and interests.

There was an activity planner that included a wide range of options such as tai chi, relaxation sessions, a social group, visits from a therapet, music quizzes and a gardening group. During our visit we saw people enjoying quiet time watching TV; there was also a quiz taking place and earlier in the day, there had been relaxation therapy and an exercise group.

We were pleased to hear that not all activities took place on the ward; there was also a minibus that was used for outings. The hospital chaplain also visits weekly, offering spiritual comfort and was also available on request. There is a local hairdresser and podiatrist who regularly visit the ward offering a service.

Each person on the ward had an individual activity plan which was discussed and agreed at the time of their admission or when their needs changed. We were pleased to see person-centred activity care plans that were regularly reviewed and updated. The activities that each person took part in or declined were recorded in their care records in MORSE.

The ward also had OT and an OT support worker who both work part-time and offered an assessment of functional needs, helped patients re-engage in meaningful activities, promoted social inclusion, provided opportunities to build confidence, budgeting and shopping. They also ordered any aids, adaptions or equipment needed to support discharge. Both staff members helped individuals on the ward navigate housing and benefit systems.

The staff and individuals we spoke with were complimentary and positive about the activity and occupation available on the ward. We were pleased to hear positive comments from staff who lead activities and who informed us, “there’s great respect for each profession,” “staff are always open to ensure activities that are on offer include each person.”

The physical environment

On entering the ward, we found it to be clean and it was quiet with a sense of calm. There was a lounge area and a separate dining area, as well as a quiet room and an additional room that was used as the MDT meeting room. These rooms were bright and spacious.

The ward had direct access to outside space with robust garden furniture and raised beds which were being planted up. We heard the gardens are open during the day when the weather is good and were told that people like the outside space, which helped them with their recovery. We were also aware that access to this space was risk assessed on an ongoing basis to ensure it is safe and staffed when needed.

The ward had nine single rooms with toilets and hand washing facilities. There were two four-bedded dormitories and a six-bedded dormitory, all with toilet and shower facilities. There was a large, assisted bathroom for people who preferred a bath.

We heard from relatives and people on the ward that they found the level of cleanliness to have a positive therapeutic effect on their wellbeing. However, they felt the hallway was tired and bland, which we agreed with. While staff had tried to make the place more homely by putting photographs on the wall of different activities, we felt further work was needed to make the main ward areas more homely and welcoming. We were of the view this was also needed in the bedrooms.

We heard at the feedback meeting at the end of the visit that the décor and starkness in some areas of the ward was discussed with managers at the mental health wards meeting. We were pleased to hear that there are plans in place for a programme of ward decoration. We also heard of the planned work to install new doors to reduce ligature risk which begins in the hospital in June 2025.

We heard that the water cooler, which has been broken for months, was waiting to be repaired however there was a debate in relation to who paid for this, which was causing the delay. The disagreement about cost should not prevent access to cool water when required. Access to water is essential for the people who are on the ward to ensure hydration and promote independence and wellbeing.

Recommendation 1:
Managers in the hospital should prioritise the repair of the water cooler and ensure that individuals on the ward always have independent access to water.

Summary of recommendations

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Managers in the hospital should prioritise the repair of the water cooler and ensure that individuals on the ward always have independent access to water.

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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