

## **Mental Welfare Commission for Scotland**

### **Report on unannounced visit to:**

Inverclyde Royal Hospital, Intensive Psychiatric Care Unit,  
Langhill Clinic, Larkfield Road, Greenock, PA16 0X

**Date of visit:** 24 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**

The intensive psychiatric care unit (IPCU) in Langhill Clinic is an eight-bedded unit that provides intensive care and treatment for individuals aged 18-65 years who present with an increased level of clinical risk.

On the day of our visit, there were five individuals on the ward and three vacant beds.

We last visited this service in December 2024 on an announced visit and made a number of recommendations. These related to person-centred care planning, the audit of care plans, risk assessments, and medication records for individuals requiring certificates to authorise their treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). There were recommendations that related to rights and restrictions, activity, and adherence to the legislation regarding hospital buildings being smoke free.

The response we received from the service was that designated staff would carry out weekly reviews of care plans and the senior charge nurse (SCN) or charge nurses (CNs) would undertake monthly audits of care plans. Findings from the audits would be discussed during individual supervision and additional support would be sought from the nurse practice development (PD) team. The SCN would also undertake monthly audits of risk assessments and ensure nursing staff attended relevant training.

In relation to consent to treatment and authorising treatment, nursing staff would be identified to carry out a weekly check of T2 and T3 documents and these would also be discussed at weekly multidisciplinary team (MDT) meetings. All paperwork in relation to specified persons was to be completed by the responsible medical officer (RMO) and medical secretaries would ensure that staff in health records were made aware of the requirement for this. Staff were identified who would be responsible for ensuring written notification was provided to individuals where appropriate.

Regarding activity, designated staff would be responsible for supporting meaningful activity over weekends and any activity would be documented.

The response from the service relating to a smoke free environment was that the SCN would ensure all nursing staff completed the relevant online training and were aware of their responsibilities in maintaining this. Any breaches of this policy would result in a record being completed on the risk management information system, DATIX which records incidents, hazards and near misses.

During our last visit, we were pleased to hear that a feasibility study was planned for IPCU to ensure that funding was available to maximise and improve recreational space. Unfortunately, this work had not progressed at the time of our visit.

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 upon care and treatment.

### **Who we met with**

We met with, and reviewed the care of five people, three who we met with in person and two who we reviewed the care notes of. We also spoke with one relative.

We spoke with the service manager (SM), the senior charge nurse (SCN), and the responsible medical officer (RMO). We also spoke with the lead occupational therapist (OT), two social workers who were mental health officers (MHOs) and a pharmacist.

### **Commission visitors**

Gemma Maguire, social work officer

Laura Young, nursing officer

## **What people told us and what we found**

We heard from the individuals that we spoke with that staff were “good” and that nursing staff were “very accommodating” of their needs. Individuals spoke positively about their care, and one individual described feeling “safe”.

There were mixed views on the food provided. One individual said that the food was “not good” while another described the food as “great”.

All individuals that we met with told us that they were aware of their rights and were either involved with or had access to advocacy.

A relative that we spoke with informed us that they could speak with staff and the doctor when they visited and that they ‘knew what was happening’ with their loved one.

Members of the multidisciplinary team (MDT) that we met with described positive working relationships, that communication was good and team members worked well together.

We were disappointed to hear that the service had not managed to recruit to the vacant psychology post. The post has been advertised as a fixed term contract which may be a causal factor as to why it has not been successfully recruited to. The service is continuing to try and recruit to this post. Feedback from the previous visit had highlighted how invaluable this service had been in providing a trauma informed, recovery-based approach for individuals. Members of the MDT shared our disappointment, acknowledging how valuable this service had been for both individuals on the ward and staff who worked there.

On the day of our visit, we discussed discharge planning alongside where individuals were boarded in and out of the IPCU. The SCN informed us that there were general issues across the hospital in relation to this. We heard that steps were being taken to progress this and we saw evidence of on the day of our visit.

## **Care, treatment, support, and participation**

We were pleased to find most care records, including care plans, MDT records and risk assessments were accessible on the electronic recording system, EMIS. The only exception was the continuous intervention plans which were in written format.

### **Care plans**

After our last visit, we made a recommendation regarding person-centred care planning and the review of these. We were advised that improvements had been made by the service through a care plan audit process, although recording has been adversely affected with the introduction of a new care plan template.

We were disappointed to still find inconsistencies with the care planning process, despite the introduction of the care plan audit tool. On review of the care plans we found some areas of good practice where reviews were detailed and provided clear evidence of progress toward the goals; others lacked detail and had key information missing. There was limited evidence of individuals' involvement in their care plans.

On the day, we discussed this with the SCN who advised that the care plan template continues to adversely affect the quality of care plans; this has again been escalated to senior managers. We discussed the possibility of seeking support from the nursing practice development team to support nurses develop their skills in relation to care planning.

We signposted the SCN to the Commission's [good practice guide on care plans](#)<sup>1</sup>. This is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability. This resource could assist nursing staff in the development of meaningful, person-centred care plans.

**Recommendation 1:**

Managers responsible for the IPCU should carry out an audit of nursing care plans and reviews to ensure they reflect progress towards individualised goals.

**Recommendation 2:**

The managers responsible for the IPCU should ensure individuals' involvement in the care planning process and ensure this is documented.

**Risk assessment**

At the time of our last visit, we recommended that managers responsible for the IPCU should carry out an audit of risk assessment documentation to ensure consistency of recording and review.

We were pleased to see that all individuals had a risk assessment in place. In NHS Greater Glasgow and Clyde, the Clinical Risk Assessment Framework for Teams (CRAFT) is used. There was clear and relevant historical risk information documented in the CRAFT, however there was key information on active risks that was missing from some individual's assessments. It was noted that strategies to manage identified risks were limited.

We discussed this on the day of our visit with the SCN and SM, who acknowledged that their current audit processes focused on each component of the assessment being completed rather than the quality of the content.

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<sup>1</sup> *Person-centred care plans good practice guide*: <https://www.mwscot.org.uk/node/1203>

**Recommendation 3:**

Managers responsible for the IPCU should ensure that the risk assessment audits have a focus on identification of active risk supported by evidence and risk management strategies specific to the risk identified.

**Multidisciplinary team (MDT)**

MDT meetings are held weekly and are attended by the RMO, occupational therapist (OT), pharmacist, patient activity co-ordinator (PAC) and a member of the nursing team. As indicated earlier there is currently no psychologist in post. We were advised by the mental health officer (MHO) that they were also invited to the MDT.

On reviewing the MDT records, it was documented who attended, including the individual and their carer (where appropriate) with their views recorded and clear actions noted each week. One individual had only recently been re admitted, but on review of the records from previous admissions, MDT records were consistent.

We were advised that the lead OT was leaving but a succession plan was in place and that the current OT vacancy was to be advertised so that there was cover for the community mental health team (CMHT) and inpatient services. At the time of our visit there were no vacancies for psychiatry, registered nurses, or health care support workers.

There was a patient activity co-ordinator (PAC) in post, and this was viewed positively by individuals and staff.

**Use of mental health and incapacity legislation**

On the day of our visit, four individuals in the IPCU were detained under the Mental Health Act). There was one individual detained under the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act). Information relating to the individuals' detention was easily accessible and there was evidence in the records of when a person's detention status changed.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained and who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2Bs) and certificate authorising treatment (T3Bs) were in place where required and corresponded to the medication being prescribed.

There were no individuals receiving medication covertly at the time of our visit.

For those individuals that were under the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) we found documentation to be accessible with details of granted powers, and the views of the attorneys clearly recorded in the care records.

## **Rights and restrictions**

The IPCU has a 'locked door' policy which is proportionate to the level of risk being managed in this setting.

Individuals have access to an enclosed garden space, supervised by staff at various intervals throughout the day. It was noted that closed-circuit television (CCTV) was in operation over the garden area, but no visible signage was in place to indicate this. We advised that this is something that should be put in place so that anyone accessing the garden area is aware of CCTV being in operation.

The Mental Health Act introduced the concept of 'specified persons' in respect of authorising restrictions on individuals' correspondence, use of telephones and in relation to safety and security in hospitals. Sections 281 to 286 of the Mental Health Act and their associated regulations provide the framework in which restrictions can be placed on individuals 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.

At the time of our last visit, we made recommendations regarding medical staff ensuring reasoned opinions were provided for all restrictions applied to individuals specified under the Mental Health Act and when someone is made a specified person, medical staff should provide individuals with written information regarding restrictions imposed, timescales for review and information about their rights.

On the day of our visit there were two individuals specified persons applied to. In one instance we were pleased the paperwork was easily accessible and appropriate, however in the second instance, the relevant paperwork was missing. We spoke with the SCN regarding this who was aware of the restriction and advised they would follow this up as a priority.

When an individual's RMO decides that restrictions should apply, they must first designate the individual as a specified person. At that time, individuals should be given written information regarding any restrictions that are in place, the timescales for review and information about their rights.

The Commission has produced [good practice guidance on specified persons](#)<sup>2</sup> and managers should consider training for the MDT in the application and use of specified persons.

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<sup>2</sup> *Specified persons good practice guide*: <https://www.mwscot.org.uk/node/512>

**Recommendation 4:**

Medical staff in the IPCU should then ensure appropriate notification paperwork is completed in relation to restrictions being implemented and record a reasoned opinion for imposing restrictions.

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 advance statements in individuals case records. We were advised by the SCN that this is discussed on admission and before discharge where appropriate. The SCN advised that advance statements now feature on the admission checklist.

The Commission has developed [Rights in Mind](#).<sup>3</sup> 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.

There was clear evidence of meaningful involvement of advocacy. We were pleased to find that everyone we met with had involvement with or knew how to access advocacy; many had solicitors and/or named persons in place. Information regarding advocacy input was also included in some of the care plans we reviewed.

We were pleased to see that written notification had been provided to an individual when an extension was made to their detention, which included contact details for advocacy and the Mental Welfare Commission.

On the day of our visit, there were initially two individuals subject to continuous intervention. One individual was reviewed and their continuous intervention ended during our visit. We found no paperwork in place to support the continuous intervention for one individual and advised staff that this should be completed as soon as possible and be available to the care team.

**Activity and occupation**

We were provided with feedback from both staff and individuals on how valuable the PAC was.

There was evidence in some care records of activity taking place and we saw individuals playing pool and engaging in art during our visit; we received feedback during our visit that playing pool was not accessible for everyone. We would expect all activities to be risk assessed and accessible to all individuals in the unit.

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<sup>3</sup> *Rights in Mind*: <https://www.mwscot.org.uk/law-and-rights/rights-mind>

There is input from occupational therapy (OT) who undertake assessments and provide one to one support. There was also one individual who was engaging in cooking sessions with OT.

When we last visited, we recommended that managers should ensure that individuals have access to meaningful activity and occupation seven days per week. The introduction of the PAC has helped to expand the opportunity for activity however there is an impact on what is available when the PAC is not in the IPCU.

There were some individuals who had access to 'supervised time out' which was determined based on assessment of risk.

### **The physical environment**

The IPCU was clean and all bedrooms were single occupancy with en-suite facilities.

There was one area designated for recreational activities which was shared with the Acute Adult Assessment Unit (AAU). The SCN advised us that access was managed between the two units with no significant issues arising. Individuals we spoke with enjoyed accessing this area, although one individual described the space as 'tight'.

There was no designated quiet space that individuals could access or that could be used for the purpose of de-escalation. We spoke with the SCN regarding this who advised that this was something they had raised previously however no progress had been made regarding this.

At the time of our last visit to the service, we heard that funding was in place to create a recreational activity area in the outdoor garden, with a feasibility study being progressed to consider the best way to make improvements. We were disappointed to hear that this work has not progressed since our last visit and would urge managers to ensure this is addressed, given the limited indoor space currently available for individuals in the IPCU.

#### **Recommendation 5:**

Senior managers responsible for the IPCU should ensure the work is progressed to create a recreational activity area in the outdoor garden area.

We note that there was damage to one part of the perimeter fence of the enclosed garden area and raised this as a safety concern. The SCN advised that this had been the result of storm damage and had been escalated to senior managers.

#### **Recommendation 6:**

Senior managers responsible for the IPCU should make plans for the perimeter fence of the garden area to be repaired as a priority.

On the day we visited, the main entrance, which is shared between IPCU and AAU, was littered with cigarette ends, requiring anyone who entered the building to have to try and step over these.

In Scotland, it is not lawful for anyone to smoke in hospital grounds. We discussed this issue with the SCN on the day of our visit. The SCN informed us that it related to individuals from the adjacent service and that individuals from the IPCU do not have access to cigarettes and do not smoke at the shared main entrance to Langhill Clinic.

The SCN confirmed the service has policies in relation to hospital buildings being smoke-free. We were informed that individuals are advised not to smoke on hospital grounds and despite nicotine replacement therapy (NRT) being available, some continue to smoke in the areas outside the wards.

The Commission advises services that the legislation relating to smoking on hospital grounds must be enforced as to do so 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 use NRT. We acknowledge the advisement from the SCN that individuals from the IPCU do not smoke at the main shared entrance however we feel it is the responsibility of managers as a whole to ensure policies are followed and legislation adhered to.

We made a recommendation regarding this at the time of our last visit, and this continues to be a recommendation.

**Recommendation 7:**

Managers should ensure that legislation and local procedures are adhered to in relation to hospitals buildings being smoke free.

## **Summary of recommendations**

### **Recommendation 1:**

Managers responsible for the IPCU should carry out an audit of nursing care plans and reviews to ensure they reflect progress towards individualised goals.

### **Recommendation 2:**

The managers responsible for the IPCU should ensure individuals' involvement in the care planning process and ensure this is documented.

### **Recommendation 3:**

Managers responsible for the IPCU should ensure that the risk assessment audits have a focus on identification of active risk supported by evidence and risk management strategies specific to the risk identified.

### **Recommendation 4:**

Medical staff in the IPCU should then ensure appropriate notification paperwork is completed in relation to restrictions being implemented and record a reasoned opinion for imposing restrictions.

### **Recommendation 5:**

Senior managers responsible for the IPCU should ensure the work is progressed to create a recreational activity area in the outdoor garden area.

### **Recommendation 6:**

Managers responsible for the IPCU should plan for the perimeter fence of the garden area to be repaired as a priority.

### **Recommendation 7:**

Managers should ensure that legislation and local procedures are adhered to in relation to hospitals 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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