

Mental Welfare Commission for Scotland

Report on announced visit to: Gigha Forensic Rehabilitation Ward and Iona Low Secure Ward, Beckford Lodge, Caird Street, Hamilton, ML3 0AL

Date of visit: 16 March 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

Gigha Ward is a 12-bedded, mixed-sex forensic rehabilitation unit on the purpose-built Beckford Lodge site. The ward provides a step down from the low secure forensic wards. On the day of our visit there were 12 individuals on the ward.

Iona Ward is 15-bedded, purpose-built, low secure forensic mental health ward providing care and treatment for male forensic patients across NHS Lanarkshire.

Individuals from both wards can access Caird House, which is on the Beckford Lodge grounds; there they have access to the large kitchen for group work, a spacious outdoor garden area, with access to gardening activities, outdoor seating, and to a bicycle maintenance shed. There is a studio in the grounds of Caird House for art project work with individuals.

We last visited this service in August 2024 and made recommendations regarding the auditing of care plans to ensure they are person-centred, with clear goals and reviewed regularly. We made a recommendation about ensuring information was easily accessible with both paper and electronic recording systems, that consent certificates were up to date and authorised the correct medication, and that enhanced observations were recorded and reviewed in care records.

The response we received from the service was that these recommendations had been addressed.

On the day of this visit we wanted to follow up on the previous recommendations and hear from individuals and staff about how the service was managing with the demand for low secure placements.

Who we met with

We met with, and reviewed the care of 12 individuals, 10 who we met with in person and two who we reviewed the care notes of. The wards had advised relatives of our visit, but there were no requests to meet with us or for contact about the visit.

We spoke with the service manager, the senior charge nurse, the lead nurse, occupational therapist and consultant psychiatrist.

Commission visitors

Alison Thomson, nursing officer

Laura Young, nursing officer

Justin McNicholl, social work officer

Karen Beattie, nursing officer

What people told us and what we found

Individuals that we spoke with were positive regarding the care they were receiving from all staff. We heard comments such as “the staff know me well”, “staff are all good, they are kind, and they listen”, and “I like the doctor and the staff”. We observed positive and compassionate care being delivered to the individuals in both wards.

Individuals in Gigha Ward commented on the activities that were available in the ward; they particularly enjoyed the pool, groups and football. Feedback from individuals in Iona Ward varied about the activities that were available. Some stated that there was good access to groups, such as the walking and bicycle groups; some felt there could be more on offer. We were pleased to find that people were supported and enabled to uphold their religious beliefs and observances, including maintaining links with local mosques and churches.

We heard that people felt safe in the wards and they spoke positively about the clinical team who supported them. Both Iona and Gigha Wards had a welcoming atmosphere and we were told staff were always available if needed. Throughout the visit, the interactions we observed that took place between individuals and staff demonstrated staff had a good knowledge of the individuals’ needs. Individuals told us that they spend time with the nurses on a one-to-one basis and highlighted that the individual sessions could be either initiated by the person or the nurse.

Individuals told us they felt involved in their care and were included when there were multidisciplinary team (MDT) and care programming approach (CPA) meetings. CPA is a multidisciplinary framework used to provide structured care for individuals with complex mental health issues; as a framework, CPA enables co-ordinated and robust assessment, planning, care management and review.

In both wards we heard comments about the food on offer. The feedback was mixed with some commenting that the food was “nice”, or “great” although we heard from someone that it was “atrocious”. We heard that individuals were encouraged to make their own meals in Gigha Ward and had access to a kitchen, with a pantry, cupboard space, and fridge to store and make their preferred meals. We heard about the innovations in Gigha Ward around the pantry system and how this was encouraging individuals to cook healthy meals on the ward and promoted a sense of community.

Individuals in Iona and Gigha Wards had access to their own en-suite bedrooms that were modern and bright.

Care, treatment, support, and participation

Care records

NHS Lanarkshire uses the MORSE electronic recording system and we found the information that we required from different parts to be easily accessible.

The daily progress notes used a structured format which provided detail of individuals' care and treatment, including documentation about their mental state, and a record of how the individual had spent their day. One-to-one sessions focussed on the person's wellbeing, their understanding of their illness, and the stage they were at in their recovery. The one-to-one sessions were recorded either as a stand-alone entry or in the daily notes. We were advised these were regularly audited by the senior charge nurses in the wards.

We reviewed 12 individuals' files and found that risk assessments were completed appropriately, regularly reviewed, and highlight relevant areas of risk.

We viewed the Historical, Clinical and Risk Management 20 (HCR -20) reports that had been completed for everyone we reviewed. We found that these were completed to a high standard, and individuals told us they felt part of this process.

The current risk assessments categorise risk with red, amber, and green coding. We were told NHS Lanarkshire are piloting a new risk assessment that moves away from categorising of risk in this way and which is more in line with current evidence. It is being piloted with a view to being rolled out across NHS Lanarkshire. We look forward to hearing more about this when we next visit.

In the records we reviewed, all individuals were managed under CPA, with regular meetings that took place with individuals and relatives/carers. Where individuals were in agreement, they were invited to attend these meetings. Those we spoke with in both Gigha and Iona Wards told us that they were aware of their CPA meetings and the plans associated with these.

The care plans we viewed were mostly comprehensive and demonstrated a person-centred approach. It was evident that the care plans were regularly reviewed and it was clear when progress had been made. The views of individuals were recorded in most of the records we accessed, although there were some records where it could have been made clearer whose views were being documented.

It was evident that engagement had taken place for people who wished to participate. For people who do not wish to participate, or whose level of functioning did not permit active participation, we advised staff to ensure that this was recorded in the care plans to demonstrate that participation had been encouraged. The level of detail made it easy to identify individuals' strengths and their future wishes.

MORSE has space for four care plans for each person which meant that a number of goals were explored on each. During the visit, we found that additional care plans were stored on a shared drive. These care plans were formatted in a way that was much easier to read. We were advised that in future all care plans were incorporated in the three care plans system available on MORSE.

Recommendation 1:

Managers should ensure there is a consistent approach adopted to the storing of records which allows ready access to care plans.

We could see that from the records that collaborative decisions about changes in care were also discussed at the time when individuals participated in MDT and CPA meetings. This was then documented for the rest of the MDT through recordings on MORSE. The record of the MDT was then transferred into actions and outcomes in the electronic notes, in addition to the MDT record. This made it clear to see where there was progress and what the intended plans were.

Multidisciplinary team (MDT)

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

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and provide an update on their views. The MDT also included the views of individuals and their families/carers. There were links between the MDT decisions that had been made being followed through in the care plans we reviewed.

Use of mental health and incapacity legislation

On the day of the visit, six individuals from across the two wards were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act); 20 individuals were detained under the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act); one individual was informal and there was one individual was under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

All of the individuals we met with had a clear understanding of their legal status and those that we spoke to had access to mental health officers, lawyers, and advocacy staff as and when required. Individuals told us it was easy to access external professionals. We heard about the work with advocacy who aimed to have weekly ward meetings to support individuals and about the carer's information board.

All documentation relating to the Mental Health Act around capacity to consent to treatment was in place in the electronic and paper files.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed, with the exception of two individuals whose T3s had errors around off licence prescribing; designated medical practitioners (DMP) were contacted while we were on the visit to address this. We found that the remaining T3s had been completed by the responsible medical officer (RMO) to record non-consent and these were available for staff to access.

We saw evidence of pharmacy involvement in the audit of the T2 and T3 certificates to ensure the prescriptions were in line with legal authority to treat, with the results were fed back to the RMO, the service leads, and nursing staff with action points where required.

Recommendation 2:

Managers, medical staff, and pharmacy should ensure that all consent certificates and certificates authorising treatment are up to date with prescribed medication with the specific information about off licence prescriptions.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We discussed the use of named persons nominations and the use of advance statements with staff and individuals. The staff had a person-centred approach when discussing these, finding a time when the individual would be able to make an informed decision about this. The discussion was then recorded in the care plans and in MDT notes. We were told by individuals that they were encouraged to think about named persons and advanced statements and knew how to access support for this.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. Individuals subject to the AWI Act require to have a section 47 certificate in place to authorise medical treatment, although this does not cover treatment under the Mental Health Act. There was one individual who had a section 47 certificate in place.

Rights and restrictions

The main door to Gigha Ward was unlocked and individuals could come and go freely. In Iona Ward, the main door was locked. There was information on the wall at the entrance of the ward that described why the door was locked and how to exit.

There were two individuals were on continuous intervention (CI) in Iona ward, and one individual in Gigha Ward. On reviewing the documentation for CI, we found that all paperwork was in order, with clear, regular assessment and reviews around the rationale for continuous intervention for the individuals. The staff in Iona Ward were in the process of developing training to support other areas of NHS Lanarkshire with continuous interventions.

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 made a specified person in relation to these sections of the Mental Health Act and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of the visit, there were 15 people who were specified persons on Iona Ward in relation to safety and security provisions, and 10 on Gigha Ward who were made subject to specified person status on a case-by-case basis. We found that all paperwork relating to this was accessible.

The individuals we spoke to who were specified were aware of this and their rights in relation to reviewing this.

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. There was one individual with an advanced statement in Iona Ward and a copy of the advanced statement was uploaded to MORSE and documented in their care plans. We found evidence that advanced statements were discussed with individuals at different stages of their stay in the wards.

The Commission has developed [Rights in Mind](https://www.mwscot.org.uk/law-and-rights/rights-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

We saw evidence of and individuals told us about a broad range of activities that were available in the wards. Activity and occupation was provided by occupational

¹ *Rights in Mind*: <https://www.mwscot.org.uk/law-and-rights/rights-mind>

therapy, and nursing staff. Nursing staff, across both inpatient and community settings deliver meaningful activity.

We were told the introduction of the Continuous Intervention Policy has supported a more consistent and varied approach to activity provision, with interventions being recorded in line with policy requirements.

The variety of activities available to individuals in the wards included biking and walking groups, access to a games room, pool, darts, football, books, movie nights, gym and access to TV and an iPad.

For those with access to the community, they were able to attend various activities as arranged by the occupational therapy staff who facilitate the project, Branching Out, as well as access to Caird House which met the specific interests of those in the wards.

The occupational therapist provided an overview of the ongoing and planned work for forensic occupational therapy which included risk-focussed interventions, vocational rehabilitation, group work, and where a sensory assessment pathway was embedded into the person's treatment objectives.

The physical environment

The décor in the wards was in good order and we found that the ward environments to be bright and clean.

Gigha Ward has single bedrooms, all with en-suite bedrooms. There are two bedrooms in the ward which are specially adapted to support those with physical disabilities. Individuals were encouraged to personalise their rooms. The unit has four lounge areas, activity space, assessment kitchens, and laundry facilities for individual use.

Iona Ward has 15 en-suite bedrooms, and again, individuals are encouraged to personalise their own space. The ward has an activity area, three lounges, and a gym for patients to use.

On the first floor of Gigha Ward there is a quiet room which staff use to undertake therapies with patients and when not in use, this area could be used by individuals who wanted to relax.

There is enclosed outside space that patients can access directly from the ward.

Summary of recommendations

Recommendation 1:

Managers should ensure there is a consistent approach adopted to the storing of records which allows ready access to care plans.

Recommendation 2:

Managers, medical staff, and pharmacy should ensure that all consent certificates and certificates authorising treatment are up to date with prescribed medication with the specific information about off licence prescriptions.

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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