mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to:
Parkside North and Parkside South Wards, Cleland Hospital, Bellside Road, Cleland, ML1 5NR

Date of visit: 7 April 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

Parkside North Ward is a 15-bedded, all-male ward and Parkside South Ward is a 15-bedded, all-female ward. The age range of the patient group is varied, from mid-50s upwards. Most of those people in the wards have long standing mental illness and complex care needs.

Some of the beds are designed for slow stream rehabilitation, some for those with non-organic (functional) mental illness who require health board continuing complex care (HBCCC) and more recently, due to the closing of the NHS specialist dementia HBCCC beds at Hattonlea Care Home, some beds are being used for those whose needs relate to a diagnosis of organic mental health.

At the time of our visit, there were 11 individuals in Parkside North and 12 in Parkside South.

We last visited this service in August 2023 and made recommendations regarding the use of paper and electronic recording and that information was replicated across the systems ensuring it was easily accessible. Consent certificates were required to be up to date and authorise the correct medication, and section 47 certificates were to be completed appropriately. 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 supporting individuals with specific needs in relation to organic mental health, namely dementia, due to the closing of Hattonlea Care Home.

Who we met with

We met with, and reviewed the care of 10 individuals, five who we met with in person and five who we reviewed the care notes of. The wards had advised relatives of our visit, and one family was able to meet with us; we received no contact from other relatives about the visit.

We spoke with the service manager, the senior charge nurse, and the lead nurse.

Commission visitors

Alison Thomson, nursing officer

Laura Young, nursing officer

Anne Craig, social work 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 are kind", ''I can't fault the staff'', and "the staff are available when I need them''. We observed positive and considerate responses being delivered to the individuals in both wards and there was a welcoming atmosphere.

We heard that people felt safe in the wards and they spoke positively about the clinical team who supported them.

We were told staff were always available if needed. The interactions we observed that took place between individuals and staff demonstrated that staff had a good knowledge of the individuals' needs. Individuals told us that they spent time with the nurses on a one-to-one basis, that they felt involved in their care and that if they chose to, they could take part of the multidisciplinary (MDT) meetings.

Some individuals in both wards commented on the lack of activities available. There were some comments about "boredom, because there is nothing to do". The diverse needs of the individuals in the wards, where the focus could be on rehabilitation, functional and organic mental health issues, created challenges for staff in facilitating activities that met the needs of all.

We were advised that previously, the services had access to a minibus and this was used for trips, but the bus is out of service and no longer available. We were also shown the garden areas, which were being improved to ensure they were safe for use.

We heard that since Hattonlea had closed, the dementia specialist team have arranged stress and distress and specialist dementia training for staff; relatives told us that this has improved the care for their loved one. Relatives told us that specialist input from Alzheimer's Scotland and the Dementia nurse consultant had been sought, in order to support the introduction of individuals with dementia who required the HBCCC beds in Cleland Hospital.

Individuals in both wards had access to their own bedrooms and these were modern and bright. The ward environment was bright and clean with personal touches that softened the clinical feel.

Care, treatment, support, and participation

NHS Lanarkshire uses the MORSE electronic recording system. The information was easily accessible and it was clear how to access different parts of the system.

The daily progress notes used a structured format which demonstrated the progression in the care and treatment, including documentation about the individuals' mental state and a record of how the individual had spent their day.

One-to-one sessions focussed on the person's wellbeing; they provided an understanding of their illness and the stage of their recovery. The one-to one sessions were recorded either as a stand-alone entry, or in the daily notes. We were advised these are regularly audited by the senior charge nurses in the wards.

We reviewed 10 individuals' files and saw that risk assessments were completed appropriately, regularly reviewed, and highlight relevant areas of risk. The current risk assessments categorised risk with red, amber, and green coding. We were told NHS Lanarkshire are piloting a new risk assessment that takes a more current view of risks, with plans to roll this out across NHS Lanarkshire. We look forward to hearing more about this when we next visit.

The care plans we reviewed were comprehensive and demonstrated a clear person-centred approach. It was apparent 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. It was evident that engagement had taken place to the level the individual and their family could manage. The detail recorded in the care plans made it easy to identify an individual's strengths and their views of their care.

We could see from the records that collaborative decisions about changes in care were discussed at the MDT meeting and documented for the rest of the MDT on MORSE. The outcomes of the MDT were transferred into actions and outcomes in the electronic notes, as well as in the MDT record. This made the progress achieved and plans in relation to care and treatment clear for the Commission visitors.

Multidisciplinary team (MDT)

The multidisciplinary teams for both wards consisted of consultant psychiatrists, nursing staff, psychology, a rehabilitation speciality doctor, pharmacy staff, a visiting GP, physiotherapy, and occupational therapy staff. The MDT meeting was held on a weekly basis and although not all of the MDT attended, they were available for advice.

The MDT meeting notes were concise, detailed, and reflected the individual's progress. They evidenced the individual's current situation and supported the ongoing decisions made. All notes were recorded using the MDT template on the MORSE system. Where the individual was able to attend the MDT, they were be invited to do so. Family members or carers were also invited to the meetings. If they were unable to attend, the nursing teams provided an update for the families or carers.

The wards were supported by a local GP practice for physical health care checks and there was a consultant psychiatrist who provided input for mental health care. There was a full-time occupational therapist who covered all individuals in Cleland Hospital. All other allied health professionals were accessed via referral.

Use of mental health and incapacity legislation

On the day of the visit, 11 individuals from across the two wards were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act); all the individuals we met with had a clear understanding of their legal status and for those that we spoke with, they told us that they had access to mental health officers, lawyers, and advocacy staff as and when required.

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

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.

We saw evidence of pharmacy involvement in auditing of the T2 and T3 certificates to ensure the prescriptions were in line with legal authority to treat. The results were fed back to responsible medical officers (RMO), service leads, and nursing staff with action points.

Where there was a proxy decision maker, either a welfare guardian or power of attorney, we found this had been documented in the person's file.

For those individuals who required covert medication, all appropriate documentation was in order, including the pathway where covert medication was deemed appropriate. We advised staff that covert medication pathways should be regularly audited.

The Commission has produced good practice guidance on the use of covert medication.

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 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.

Of the records we accessed where individuals required treatment under the AWI Act, we found section 47 certificates on file which had been completed correctly and had an accompanying treatment plan.

Rights and restrictions

The main doors to the units were key card entry and were usually locked for the safety and security of those in the wards. Staff were available to allow entry and exit to visitors, as required. There is also a receptionist at the entrance to the wards who would assist visitors with entry as appropriate.

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 discussed the use of advance statements and named persons notifications with staff and individuals. The staff take a person-centred approach when discussing these, finding a time when the individual would be able to decide about this. The discussion is clearly recorded in the care plans and in MDT notes.

We were told by individuals that they were encouraged to think about the nomination of a named person and drafting an advanced statement; they knew how to access support with this. There was one individual with an advanced statement in Parkside North Ward and a copy of their advanced statement was uploaded to MORSE and used to inform care plans and treatment.

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

Individuals told us that there was not enough to do in the wards and this led to boredom. Individuals told us they missed going out for trips on the minibus, and that taking taxis was too expensive.

Staff try to ensure individuals had access to activities on a daily basis, but this could be difficult due to the complexity of the needs of those in the wards. There was access to secure outdoor space, and local shops; staff provided support to individuals who required this.

The ward provides daily newspapers and we saw staff supporting people who wished to read the paper. The ward would benefit from an activity co-ordinator to

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

support the work of the other professionals on the ward. We were told that NHS Lanarkshire is addressing this across all mental health and learning disability services. We look forward to seeing how this progresses.

Recommendation 1:
Managers should progress/re-establish the provision of activity co-coordinators in the wards.

The physical environment

The wards had a homely feel, with personal touches evident in people's rooms. There was a high standard of cleanliness and domestic staff were very much part of the ward team. We could see the benefit of regular domestic staff to the wards as they engaged with individuals and were kind and welcoming to visitors.

There was an on-site assessment kitchen for people to use and to allow occupational therapy assessments to take place.

All bedrooms were single rooms with en-suite toilet facilities. We noticed the flooring in one of the ensuite bathrooms was damaged and were advised that this had been reported to estates.

The large communal area off the wards was pleasant and provided an area for social occasions, group work, and family visits for individuals. Although the garden area was in the process of being upgraded, it remained a pleasant space for individuals and visitors to sit in during good weather. There were some repairs to the fencing and raised beds in the garden that required attention.

Recommendation 2:
Managers should ensure repairs to the ward are undertake in a timely manner to maintain the safety of individuals in the wards.

Summary of recommendations

Recommendation 1:
Managers should progress/re-establish the provision of activity co-coordinators in the wards

Recommendation 2:
Managers should ensure repairs to the ward are undertake in a timely manner to maintain the safety of individuals in the wards

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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