Mental Welfare Commission for Scotland

Report on unannounced visit to:
Wards 19 and 20, Hairmyres Hospital, 218 Eaglesham Road, East Kilbride, Glasgow, G75 8RG

Date of visit: 1 June 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

Ward 19 is a 26-bedded unit that provides assessment and treatment for adults who have a mental illness from the South Lanarkshire area of Hamilton, Blantyre, Larkhall and Stonehouse. On the day of our visit, there were no vacant beds.

Ward 20 is a 26-bedded unit that provides assessment and treatment for adults who have a mental illness from the East Kilbride and Clydesdale areas. On the day of our visit there were seven vacant beds.

We last visited these services in April 2025 on an announced visit and made recommendations on continuation notes, family and carer involvement, accessibility of documents i.e. welfare guardianship orders, the provision of an activity co-ordinator, the temperature of the ward and smoking/vaping on the hospital grounds.

The response we received from the service was that they were undertaking monthly audits of the continuation notes and developing a template to ensure consistency across the service. Patient information packs had been developed to enhance the triangle of care work for family and carer involvement and an audit of multidisciplinary team (MDT) participation has started. A review of the mental health admission standards was being undertaken to improve consistency in access to legal documentation. NHS Lanarkshire was progressing the role of activity co-ordinator across all their mental health and learning disability inpatient services. The temperature was being monitored and action would be taken, based on the results; alternatives, including locking windows in colder months and staff attire were also being explored. Smoking and vaping was being discussed routinely at MDT, with access to smoking cessation. Staff highlighted the no smoking policy at the time of admission and had developed an information leaflet.

On the day of this visit, we wanted to follow up on the previous recommendations and hear about any developments.

We were told the service has developed additional training for nursing staff to manage complex physical health presentations in collaboration with the trainer who delivered the training on basic life support and the advanced nurse practitioners.

We were informed that NHS Lanarkshire was working on a new risk assessment, in line with best practice.

Who we met with

In Ward 19, we met with, and reviewed the care of 11 people, eight who we met with in person and three who we reviewed the care notes of.

In Ward 20, we met with, and reviewed the care of five people, one who we met with in person and four who we reviewed the care notes of.

We did not meet with any relatives in either ward as this was an unannounced visit and on the day of the visit, there was no opportunities to meet with any families or carers.

We spoke with the service manager, the senior charge nurse, the charge nurse, the senior nurse, and the clinical psychologist. We also met with four trained nursing staff, two clinical support workers, and a student nurse.

The senior charge nurse (SCN) post in Ward 19 was being covered temporarily by an acting SCN to provide stability. We heard that the due to the level of acuity of those in the wards, staffing was difficult when enhanced observations were required; there had also been several staff off on sick leave.

Commission visitors

Alison Thomson, nursing officer

Gemma Maguire, social work officer

Graham Morgan, engagement and participation officer

Denise McLellan, nursing officer

Gordon McNelis, nursing officer

What people told us and what we found

On the day of the visit, we spoke to individuals who were positive about the care in Wards 19 and 20. They complimented the staff, telling us that “the staff are lovely”, it is a “great ward”, a “wonderful place”, and most people told us they felt safe.

One individual said they did not feel safe in the ward due to the dormitory style arrangements for sleeping. Another individual had not liked the dormitory initially but now preferred it to a single room, preferring that other people were nearby. There were comments that staff were trying to make the ward a better place and that staff made an effort to engage with individuals and their families.

We heard that friends and families were welcomed into the wards, which helped some individuals. One individual raised concerns about young people being on the ward. We were advised by staff there is a comfortable family area out with the ward which can be used by families with young children. We were told by one individual from each ward that the environment was “too noisy”.

Individuals were positive about the input from the peer support worker. One person felt she was more accessible than nursing staff and easy to speak to.

We were told there were more activities than there used to be, but some people felt there could be more on offer at times. Some individuals spoke about ‘boredom’ on the ward. Several individuals commented that the wards were busy, and at times there were not enough staff.

We were told the food was “good” and staff made sure special diets were catered for.

Another individual told us they were included in decisions about their care and felt involved. We heard that people were invited to MDTs and said their “consultant understood them”.

Most individuals we spoke to were positive about their experiences in Wards 19 and 20.

We saw staff interacting with individuals in a kind, professional manner. Staff were knowledgeable about the individuals on the wards and had a comprehensive understanding about their physical and mental health care needs.

Care, treatment, support, and participation

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

The charge nurse in Ward 19 is a basic life support trainer and she had developed training with the advanced nurse practitioners (ANP) to support the development of skills in the nursing team.

It was evident that there was regular liaison with specialities such as speech and language therapies (SaLT), dietetics, physiotherapy, and other medical specialities.

Decisions about where best to care for individuals were reviewed regularly in line with their needs, and one individual had been moved to an alternative ward to best suit their needs. We noticed joint working between mental health and general health services while we were there, and this was evidenced throughout the clinical notes.

We noticed an emphasis on including relatives and carers and strengthening the triangle of care.

Wards 19 and 20 are situated in Hairmyres General Hospital. The ability to refer people to medical and surgical services and the capacity of colleagues to review people in Wards 19 and 20, due to the availability of ANPs and the medical emergency response team, when people were acutely physically unwell, is clearly of benefit to the people in Wards 19 and 20.

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

Two of the individuals in Ward 20 were on enhanced observations at the time of the visit. The individuals expressed that they were more able to engage with staff during enhanced observation. We were told that one-to-one sessions did not always go ahead due to the activity of the ward. Individuals told us that when there are more enhanced observations, the number of unfamiliar bank and agency staff increases and this can affect planned care. We were told by staff there had been high clinical acuity in both wards, which had had an impact on their ability to undertake one-to-one's and activities.

Care records

Electronic records are stored on MORSE, and some information was held in paper files on the ward, such as detention paperwork and section 47 certificates. We reviewed the electronic records on MORSE and found the information was easily accessible.

We reviewed the daily continuation notes which were completed during the day and at night. These summarised the person's mental state, any changes in their presentation, activities that they were offered and the individuals' ability to participate in them. The continuation notes were consistent, clear, and concise, with current risks and actions noted. The content covered all the legal aspects required but missed some of the smaller changes; we considered that this was likely due to

time constraints. We were pleased to see that the recommendation in our previous visit had been acted upon.

Each person had care plans specific to their individual needs. We found some of the care plans to be clear, person-centred, detailed, and up to date with the individual's voice evident, but in others, the care plans were more professionally focussed with no evidence of individual involvement.

For some individuals, there was evidence of family involvement in care planning. It was noted that important information from the multidisciplinary team (MDT) was not always transferred into care plans, for example, risk assessments when a welfare guardianship had been granted.

The care plans were reviewed regularly, but some of the reviews were less detailed and meaningful than others.

Recommendation 1
Managers should ensure that person-centred care plans are developed consistently with evidence of individuals' views, or where this is not possible, there is evidence of discussion and planned review.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

We saw that nursing staff recorded when they spent time with a person on a one-to-one basis. We noted that this was not happening as frequently as individuals or staff would like. Individuals told us of the value they placed on one-to-one meetings and that they would seek time with the peer support worker as an alternative.

Recommendation 2
Managers should ensure adequate staffing to enable nursing staff to undertake regular one-to-ones and to incorporate MDT and formulation insights into risk assessments, management plans, and care plans, preventing loss of important information.

Risk assessment documentation for individuals 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 reviewed the care records of an individual who was subject to measures under the Adult Support and Protection (Scotland) Act, 2007, following incidents that

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

placed them at significant risk of harm. We did not find, as expected, sufficient detail in the care plan or the risk documentation, outlining how these specific risks were being managed. We discussed this with staff during our visit and were assured that information relating to risk management would be added to the individual's care records.

We noticed there were psychology led multiprofessional formulations, but the information from these was inconsistently included in the risk assessments and management plans. These formulations could be used to enhance the risk assessment, risk management plans and care plans.

We were advised that NHS Lanarkshire has been working towards a new Lanarkshire Safety Assessment Framework (LSAF) risk assessments and will then move away from the traffic light risk assessment, in line with current guidance.

Multidisciplinary team (MDT)
Wards 19 and 20 has multidisciplinary input including psychiatry, psychology, occupational therapy, dietetics, and pharmacy.

The minutes from the weekly MDT meetings were stored in an individual's electronic care records. The minutes were detailed, specific and demonstrated changes in presentation and plans of care. The legal status of individuals, consent to treatment, medications, mental and physical health needs were reviewed at the MDT meeting.

It was clear who had attended each meeting. The involvement of individuals, relatives and carers and external professionals, such as local community mental health teams and social workers was recorded. We were told by individuals that their views, and their families views were included in MDT meetings.

There are nine MDT meetings each week for Wards 19 and 20. This is onerous on staff who attend all MDTs. The MDTs were well documented, although we found that there was no consistent follow through to the care plans, the risk assessment and management plans with, on some occasions, a brief note copied over without the full context. We considered that the inconsistency with this recording may be due to increased clinical acuity and the reduced availability of permanent registered nurses.

We heard about the psychology input to support individuals, their families, and staff. Psychology that covered both Ward 19 and 20; this was evident in the formulation work and in the input into MDT reviews.

Use of mental health and incapacity legislation

On the day of the visit, eight people in Ward 19, and 10 people in Ward 20 were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the

Mental Health Act). Two individuals were under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

In the electronic care records, we found evidence that individuals were informed about their rights and had been supported to access support in relation to this. There were posters about rights, advocacy and mental health displayed in both wards.

An admission pack provided individuals with information about their rights, legal representation, advocacy, named persons and advance statements. We noticed in some electronic notes we accessed that this was discussed in one-to-one meetings.

We were told that people could access advocacy by referral and were provided with information about this by the ward team, in the admission pack and by Mental Health Officers. We saw evidence in the clinical notes of individuals having contact with advocacy.

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

We found one individual had a welfare guardianship granted, which was reflected in the MDT but this had not been updated in the risk assessment and care plans.

All other 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. In Ward 19, 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. In Ward 20, we found six certificate which did not match the current prescription, two where a designated medical practitioner (DMP) visit had been arranged, and one where the SOP1 had been submitted. This was raised with responsible medical officers (RMO) on the day of the visit and we were satisfied with their responses.

In Ward 19, the consent to treatment certificates were reviewed at the weekly MDT, and a copy was stored in the treatment room. We were told that prior to our visit, the pharmacist was auditing T2 and T3s in Ward 20, but they were on leave at the time of our visit; we heard that the SCN planned to establish a new audit process that included registered nurses. The SCN intended to offer extra training/guidance to facilitate the T2 and T3s audits.

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. Where the individual had nominated a named person, we found details of this on file and it

was referenced along with their views in care plans. We noted that the possibility of nominating a named person was revisited with individuals and documented in their care records.

For those people that were under the AWI Act, we found alerts in the individual's notes and copies in the legal paperwork file.

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.

One person had recently had a welfare guardianship granted and this was noted in the MDT minutes, but the risk assessment and care plan noted it was in application stage. This was brought to the attention of the charge nurse.

We could see improvements in the availability of documentation since the previous visit, and the addition of the admission packs highlighted to individuals, families, and carers that copies are required.

Rights and restrictions

Ward 19 and Ward 20 have an open access policy. During our visit we noted doors at the entrance/exit were open and people were moving around freely. The exits were monitored by staff who rotated hourly to ensure that there was detailed information about who was in or out of the wards. These observations were unobtrusive and did not detract from the ambience of the wards.

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 this and where restrictions are introduced, it is important that the principle of least restriction is applied.

Where there were people with these restrictions in place under the Mental Health Act, we found that a reasoned opinion had been 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 individuals in Ward 19 or Ward 20. We noted that advanced statements

were mentioned in the admission pack and revisited with individuals during one-to-ones and at the point where a person was nearing discharge.

The Commission has developed *Rights in Mind.*[2] 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

A previous recommendation was for the service to consider progressing the provision of an activity co-ordinator. We were informed that this is still progressing and has been taken to the senior management team (SMT) for approval.

On this visit, we were told about gardening groups, crafts, and one-to-one activities. There was input from peer support workers, occupational therapists, psychology, and nursing staff.

We heard from some individuals that the activity on the ward was good, but others complained of boredom. We could see activities were on offer and heard about facilitated groups. Although the activities were mentioned in the electronic record they did not provide enough detail.

We heard about how some clinical support workers (CSW) supported people with personal care and laundry when the person could not manage on their own, and how the support would gradually reduce in line with the person's abilities. We heard this from individuals and staff but did not find detail of this in the notes. We considered that this may be due to time constraints and limited staffing.

We could see staff were trying to meet the needs of the individuals in safe, effective, person-centred ways. The clinical acuity of the individuals in the wards meant that this was not always reflected in the notes, and activity and one-to-ones were reduced when clinical demands became higher.

Recommendation 3

Managers should consider the issues around registered staffing numbers, or the size of the wards to ensure safe, effective, person-centred care can be delivered and recorded consistently.

There was access to crafts and games, to gym equipment, TV, and games consoles, as well as quiet space, a garden area for Ward 19 and kitchen equipment.

The activities on offer were tailored to the needs of the individuals in the ward

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

We are aware that NHS Lanarkshire are looking at activity provision across the board and we look forward to hearing of any enhancement to the comprehensive activities already on offer.

Recommendation 4
Managers should continue to progress the provision of an activity co-ordinator to the wards.

The physical environment

Both wards consisted of single rooms and shared dormitories. There are lounge areas, quiet rooms, and separate dining areas for people. The wards were clean and welcoming with pleasant décor. We heard that estates can be slow to progress maintenance requests which can impact on the wider ward environment, and individuals' experiences.

Ward 19 has direct access to a well-maintained garden area which is used for the gardening groups, however this has no fencing around it and requires staff supervision. We were told individuals do not always ask if they can use the garden as they are aware this takes staff away from ward business.

Ward 20 does not have direct access to outdoor space as they are situated on the first floor, so staff support is required if access the garden is requested. A secure garden may be beneficial to allow individuals easier access to the garden from Ward 19, without affecting the staffing complement.

We made a recommendation on our previous visit about smoking and vaping on the ward. We were pleased to hear that individuals were supported with smoking cessation to reduce smoking and vaping on the grounds. We saw that this was discussed with individuals and was included in the admission pack.

Any other comments

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

Summary of recommendations

Recommendation 1
Managers should ensure that person-centred care plans are developed consistently with evidence of individual's views, or where this is not possible evidence of discussion and planned review.

Recommendation 2
Managers should ensure adequate staffing to enable nursing staff to undertake regular one-to-ones and to incorporate MDT and formulation insights into risk assessments, management plans, and care plans, preventing loss of important information.

Recommendation 3
Managers should consider the issues around registered staffing numbers, or the size of the wards to ensure safe, effective, person-centred care can be delivered and recorded consistently.

Recommendation 4
Managers should continue to progress the provision of an activity co-ordinator to 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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