

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Willow Ward, Orchard View, Inverclyde Royal Hospital, Larkfield Road, Greenock, PA16 OPG

Date of visit: 11 August 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

Willow Ward is a 30-bedded unit, providing assessment and treatment for older adults with complex care needs. The ward is currently capped at 20 beds due to medical staffing issues.

On the day of our visit there were 16 people on the ward.

Willow Ward is situated in the Orchard Unit on the Inverclyde Royal Hospital site and provides a service to the Inverclyde catchment area.

We last visited this service in May 2025 on an announced visit and made recommendations on care planning and record keeping in relation to risk and proxy decision makers, treatment under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and the environment.

We received an action plan from the service in response to the recommendation that set out steps that were to be taken to address all of the recommendations that had been made.

On the day of this visit, we wanted to follow up on the previous recommendations and look at communication with relatives and proxy decision makers as well as the activity provision in the ward.

Who we met with

We met with, and reviewed the care of six people, who we met with in person and reviewed their care notes. We also met with four relatives.

We spoke with the service manager, the senior charge nurse (SCN) and the activity co-ordinator.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

What people told us and what we found

Relatives we spoke with were positive about their experience of the ward. We were told that staff are approachable and friendly and communication was good, “staff let me know if anything has happened”, “if I notice something wrong or raise an issue, they listen and deal with it.” The relatives told us that they felt confident in the care that was provided saying “I can relax knowing they are being cared for.”

We heard from staff about the development work which is being progressed with practice development nurses who are undertaking one to one sessions on care planning with staff and monitoring the progress of this through four-weekly reviews. The ward is also involved in the physiotherapy-led ‘falling stars’ programme that aims to reduce the falls risk in the ward and were advised that the consultant has met with relatives and carers to develop and agree individual treatment escalation plans.

We heard that the ward has now established a carers support group which meets regularly and provides information on a variety of topics.

We were told that a training needs analysis has been undertaken and dates have been set for further training sessions on stress and distress and the activity co-ordinator will be undertaking training in the development and use of ‘playlists for life’ so that this can be re-established in the ward.

Care, treatment, support, and participation

Information on individuals’ care and treatment was held in on the electronic record system, EMIS and the electronic medication management system, HEPMA. There were also paper files containing Power of Attorney (POA) or guardianship documentation, section 47 certificates, and Do Not Attempt Cardiopulmonary Resuscitation forms (DNACPR).

On our previous visit, we made recommendations about care planning and record keeping. On this visit we found that for all the individuals whose care we reviewed, there was a completed ‘Getting to Know Me’ and ‘What Matters to Me’; these documents gather information on individual preferences, interests, routines, and provide background information to support the delivery of person-centred care. This information was incorporated into care plans.

We found completed Newcastle formulations in most of the files we reviewed, and this was incorporated into the individuals’ care plan. The Newcastle framework and process was developed to help nursing and care staff understand and improve the care of individuals who exhibit behaviours that challenge.

Care plans were reviewed regularly, and reviews were detailed and meaningful. Care plans were updated to reflect any changes in needs or treatment which had been identified as part of the reviews.

Where occupational therapy or physiotherapy staff were involved with individuals, we found discipline-specific assessments and care plans that set out the goals and interventions; these sessions were recorded in the chronological notes.

Chronological notes were relevant and meaningful; communication with families was clearly documented. We found that where a datix report had been completed, the datix number was recorded in the notes.

There were three individuals whose discharge from hospital was delayed. One person was awaiting the granting of a guardianship order and for the other individuals, their discharges were subject to dispute resolution procedures.

Multidisciplinary team (MDT)

The multidisciplinary team (MDT) consists of nursing staff, a psychiatrist, occupational therapy staff, physiotherapy staff, a patient activity co-ordinator and psychology staff. The ward also had input from the advanced nurse practitioner and a pharmacist. Referrals are made to other allied health professionals and specialist teams, as required.

There were a few health care support worker and Band 5 nurse vacancies, which were in the process of being recruited to. The occupational therapist vacancy had been filled and the new team member was expected to start within the month.

MDT reviews recorded a summary of each individual's presentation and progress, as well as who had attended the meeting and the decisions that were made. Individuals and their relatives could attend the reviews and where they are not in attendance, feedback on the outcome of MDTs was provided by telephone or during visits.

The consultant psychiatrist offered family meetings when consideration was being given to the need for ongoing NHS care or when there were any other significant changes or decisions to be made. Consultation with the family and their views were recorded in the chronological notes and care plans.

Use of mental health and incapacity legislation

On the day of the visit, four people were detained under the Mental Health Act.

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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. Copies of the T3 certificates were attached to

individual HEPMA records enabling staff to easily confirm that treatment was appropriately authorised.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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. We found completed section 47 certificates in all the files we reviewed, and where there was a proxy decision maker, consultation had been recorded.

For individuals where a covert medication pathway was required to be in place, all of the appropriate documentation was in order.

Rights and restrictions

Commensurate with the level of risk identified in the patient group, the doors in Willow Ward are locked and entry was via a buzzer or key fob system. Information on this was provided to families and other visitors.

The ward operates open visiting, with visitors welcome throughout the day and visits taking place in individuals' rooms, in visiting rooms and in the communal areas of the ward. Posters providing information on visiting, advocacy services and local carers services were on display.

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. There were no patients subject to specified person status during our visit.

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

The ward benefits with input from a patient activity co-ordinator who works across both Willow Ward and Ward 4 of the Larkfield unit, an older adult admission ward.

We heard that while this role has potential to significantly enhance activity provision it has not yet been developed to its full potential. Work is ongoing to introduce playlists for life and football memories to the ward, however there were competing demands on the activity co-ordinator's time, including supporting attendance at hospital appointments, and ECT clinics.

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

The ward has access to a minibus which is used for outings to local community facilities, including cafes and parks.

There is currently no formal structured activity programme; most activities are one-to-one or in small groups on an ad hoc basis, responding to the needs of the individuals at the time. This can vary from taking someone to the gym to providing nail care and hand massage, or relaxation groups.

Occupational therapy staff undertake assessments and provide group and individual activity sessions. These can range from having a cup of tea and a chat, walks, craft-based activities, and music sessions. Throughout our visit we saw staff engaging with individuals, chatting, listening to music etc. We found that activity participation which was recorded in the chronological notes that we reviewed was limited and did not fully reflect the range and frequency of activities being provided.

Recommendation 1:

Chronological notes should include a record of activity participation to fully reflect the nature of care being provided.

The physical environment

The ward has single en-suite bedrooms, with several communal sitting areas. The corridors are wide and bright, and the building has an open airy feel due to the large windows.

There is an enclosed courtyard garden area with seating, an activity room and quiet visitors room which is shared with Oak Ward, off the main corridor. There is dementia friendly signage throughout the ward and many of the bedrooms we saw had personal items and family pictures on display.

There is a quiet room, which we had heard previously was to be turned into a sensory room, however this room is currently being used for storage.

Our last report included a recommendation in relation to the furnishings in the ward. We heard that new furniture had been purchased but this was not robust and had broken quickly. While the ward was bright and clean, the communal areas were sparsely furnished, clinical and stark. The ward would benefit from the provision of appropriate artwork and furniture, to provide a more stimulating and homely environment.

Recommendation 2:

Managers should review the furnishings and environment to ensure that this is fit for purpose and provides an environment which meets the needs of the patient group.

Any other comments

We previously made a recommendation about the food provided. On this visit we heard that the catering provision now meets the dietary needs of those in the ward, but choice was limited and the menu repetitive.

We were told that the ward does not have a freezer, or freezer compartment in the fridge. As a result, there is no ice to provide chilled drinks during hot weather and while ice-cream can be delivered from the catering department, this required to be used quickly before it melted; this limits people's access to treats which would have provided variety and would have been especially beneficial to the individuals who have dietary restrictions.

Recommendation 3:

Managers should investigate the possibility of providing a freezer in the ward kitchen.

Summary of recommendations

Recommendation 1:

Chronological notes should include a record of activity participation to fully reflect the nature of care being provided.

Recommendation 2:

Managers should review the furnishings and environment to ensure that this is fit for purpose and provides an environment which meets the needs of the patient group.

Recommendation 3:

Managers should investigate the possibility of providing a freezer in the ward kitchen.

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.

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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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