Mental Welfare Commission for Scotland

Report on announced visit to:
Rowanbank Clinic, 133c Balornock Road Glasgow G21 3UW

Date of visit: 8 May 2025

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

Rowanbank clinic is a medium secure facility, providing forensic services to the West of Scotland. It also provides the national medium secure service for individuals with learning disabilities.

On this occasion we visited all eight wards in the Rowanbank Clinic:

Elm, a 10-bedded facility that supplies admissions facility for males.

Hazel, a 10-bedded rehabilitation facility for males.

Elder, a four-bedded facility and Sycamore, a six-bedded facility; jointly these wards host the national medium secure service for females with learning disabilities and mental illnesses.

Pine, a 12-bedded rehabilitation facility for males.

Cedar, a 12-bedded rehabilitation facility for males.

Holly, an eight-bedded national medium secure service for males with learning disabilities.

Larch, a 10-bedded rehabilitation facility for males.

On the day of the visit, the capacity in Elder had been reduced to two beds and Sycamore to three beds, to manage patient acuity.

On the day of our visit, there were 64 people in the hospital with three vacant beds across the wards.

We last visited this service in June 2024 on an announced visit and made recommendations on the need to provide staff training on the use of the Adults with Incapacity (Scotland) Act, 2000, as well as providing clarity for staff on what part of the Act was being used for individuals. We recommended that steps were taken to improve the food on offer for individuals.

The response we received from the service was that these matters had been addressed and actioned by the service.

On the day of this visit, we wanted to follow up on the previous recommendations and to review those new to the service, those subject to soft mechanical restraint, those awaiting discharge to a lower level of security, as well as those who had made excessive security appeals.

Who we met with

We met with, and reviewed the care of 30 people, 23 who we met with in person and seven who we reviewed the care notes of. We also met/spoke with four relatives.

We spoke with the operational manager, the service manager, seven of the senior charge nurses, psychology staff, the lead for allied health professionals and the

advocacy manager. On the day of the visit, we met with the nursing staff on each of the wards we visited.

Commission visitors

Justin McNicholl, senior manager (projects)/ social work officer

Gemma Maguire, social work officer

Anne Craig, social work officer

Kirsty Macleod, engagement and participation officer

Mary Leroy, nursing officer

Susan Tait, nursing officer

Susan Hynes, nursing officer

Catriona Neil, ST6 Learning Disability Psychiatry

What people told us and what we found

At the time of our visit to the wards, there were 64 individuals in Rowanbank Clinic. We were able to visit and observe individuals in all of the wards.

The majority of the people that we spoke with said that Rowanbank Clinic was a good hospital to be in. They expressed views that they were able to get the care they needed, as and when they required this.

We received many positive comments about the healthcare assistants and nursing staff which included, “the staff are great”, “they are kind”, “approachable” “I can trust the staff” and “pretty good”. We obtained further comments that they “help all the time with everything and anything”, “the staff are brilliant”, “really good, they listen to me and mum and dad”.

These positive views were echoed by relatives who stated, “nursing staff are brilliant”, “I have seen a dramatic change for the best” and “he is now more relaxed and happy”.

Some spoke of the positive relations they had with their doctor, “he is superb”, “I trust him” and “I get to see the doctor at least once a week and we have a good relationship”. Another individual commented on the positive relationship they had with a junior doctor who was described as “thorough, he helps to keep me in good condition”. One individual stated, “I see the doctor every two weeks and I get to go to all his meetings about me”.

Compared to our last visit, no individuals or their relatives had any issues with accessing medical staff which is a positive improvement.

People told us that they valued the support that they had from their psychologist, occupational therapist and other allied health professional staff. One individual commented, “I find it quite difficult to be in hospital, but good staff make it easier”. Another commented “I appreciate the risk assessment work they are doing to look at my past and future”. Many individuals commented that the work with psychology was “hard but helpful”. We heard that occupational therapy staff help individuals to keep busy “they give me plenty to do, and I can get outings when risk assessed”. One individual stated, “the OT really makes my day”.

We received a number of comments from people and their relatives that the clinic can be affected by staff shortages. The result of which is that time out in the community can be affected. This was most notable in Pine were most people spoke of staff shortages that regularly had an impact on their agreed pass plans and the community aspects of their recovery. One individual stated, “I am waiting on a move to low security and I can’t achieve what’s being asked of me by the Government due to the staffing issues”.

One relative stated, “he should get out for 2 hours, but staff sometimes can only accommodate 1 hour or none at all, it’s very frustrating and is impacting his progress.” Another relative stated, “it not only affects him but us too; there is a direct link between the lack of staff and his progress to the community”.

Three people told us they did not want to be in the clinic any longer. One stated, “I want to go back to IPCU, I’ve been locked in more here since moving”, while another stated, “I’m fed-up waiting here for a bed in low secure” and the last stated, “I just don’t like it here and don’t like how some of the staff treat me”. The same person raised concerns about how staff had treated them over the last year, and we followed this up with the nurse in charge who confirmed that these allegations had been investigated with no evidence to support the claims.

We spoke with four relatives during the visit, and they raised issues about the food, staffing and lack of written information about the wards. The relatives spoke about how food preferences had not been supplied when there were specific dietary requirements. This was echoed by individuals indicating that food was found to be poor in quality and cold. We received comments from individuals which included, “it’s like dog food”, “I can’t eat it”, “the food is awful”, “the portions are small”, “they ignore my choices”, “its overcooked” and “there are too many pies offered”. We raised concerns during our last visit about the quality of the food and recommended that steps were taken to address this. This action to date has failed to improve the experience of many of the individuals in the clinic and we have repeated this again, even though we heard from the managers about the work they had undertaken with the catering suppliers to address the concerns raised by individuals and their relatives.

Recommendation 1:
Managers should urgently seek to address the extensive concerns raised about the food provided.

Relatives raised further concerns that lack of staffing for outings which over weeks and months was slowing their relatives’ recovery journey. We heard from the service that vacancies in the clinic had reduced, with fewer bank staff being used to cover gaps in the service. The reduction in bank staff has meant that staff are reportedly seeking increased permanent posts at the clinic. Despite this we heard repeated issues about the impact of staff vacancies on individual’s suspension of detention.

When we spoke with the extended management team, we heard that there remains a cyclical vacancy rate in the service with peaks in nursing staff when newly qualified staff are employed in the second half of the year. Despite this there remains a stable senior management team, senior nursing staff and allied health professionals (AHP).

Relatives new to the clinic raised issues about the lack of written information regarding visiting times, expectations of what visits would look like for them and how to know what to do when for their relative. We heard from managers of the ongoing work undertaken to ensure that there are information leaflets available for all visitors to the clinic.

When we visited all the wards, we saw that the staff were engaging in a positive and caring way with the people in the service. We were also provided with all the help that we needed on the day of the visit.

Care, treatment, support, and participation

Care records

We reviewed care records in paper and electronic formats, the medication charts, and a range of legal documentation that was held in folders in a paper and in electronic format.

Information on individuals' care and treatment was held in three ways; there was a paper file, the electronic record system EMIS, and the electronic medication management system HePMA.

Care plans and nursing reassessments were held on the paper system. Multidisciplinary (MDT) reviews and daily notes were held on EMIS, along with legislative paperwork. We have been hearing for several years now of the health board's plan to progress to a fully electronic system, however no date has been given for this. Similar to last year, we found the care records to be well organised, easy to navigate and the system provided the option for all professionals to record their clinical contact in the relevant sections of each individual's file.

From the daily notes we reviewed, we found that these were not always meaningful, nor did they provide a holistic view of an individual's progress. We have found during other hospital visits, notes benefit from a summary that is clear and focussed on the individual's care throughout the day. This ensures a succinct summary of people's daily care as it relates to their individualised circumstances. This approach was shared with management who agreed to look into whether to adopt this method of record keeping.

All individuals across the hospital were subject to the Care Programme Approach (CPA). This approach was co-ordinated by staff onsite and ensured that meetings for individuals took place regularly and were recorded in a consistent way. There was evidence of individuals, relatives/carers and advocacy staff participating in the CPA meeting, as well as mental health officers and social workers.

Risk assessments and management plans were also found in the care records.

We could see a wide range of information relating to each individual's specific care and treatment needs in various care plans that had clear outcomes, time scales and reviews that were linked with the weekly MDT meetings. Care plans covered a broad range of rehabilitation needs, including physical health.

Care plans

Care plans are a tool that can ensure consistency and continuity of care and treatment, through detailed plans of what interventions will be provided to meet the individual's care needs and goals. They should be regularly reviewed to provide a record of progress being made. When we last visited the clinic we found inconsistencies in the frequency of care plan reviews, with some having not been reviewed in several years.

When we asked people about their care plans, they generally knew what we meant. There was consistent evidence that individuals would sign or refuse to sign care plans. We found some alternative versions of care plans which were simplified to make these more meaningful or accessible to individuals with communication or learning difficulties. It was clear from the care plans we reviewed and from the MDT meeting minutes, that people were involved in the development of their care plans and their feedback was regularly sought. It was clear how these linked with their activities and their rehabilitation goals.

Similar to our last visit, we found a consistency in the recording of the care plans and their content. The clinic continues to hold care plan reviews on the electronic record system, EMIS. We found that all individuals had multiple plans to support all aspects of their care and treatment in the hospital. We found the majority of care plans focused on supporting admission goals, outcomes and identified what the plan of care was. The information in these plans detailed what the individual required, provided a clear understanding for staff to know what intervention was necessary to provide the support. Similar to our last visit the information in the care plans were person-centred, with a focus on recovery to support discharge.

We did find that for those whose finances were managed by the clinic, they did not have a clear financial care plan in place. We believe it would be helpful to have a clear financial care plan that detailed explicitly if the individual was subject to any formal measure i.e. corporate appointeeship or if they were managed by an individual appointee or financial guardian. Despite this we found clear spending plans in place which individuals understood along with the impact on their plans for the week ahead. We were pleased to see that thought was being given by the staff to encouraging individuals to utilise their money creatively to ensure maximum benefit.

Recommendation 2:

Managers should take steps to ensure that a financial care plan is in place for all those subject to these measures.

Multidisciplinary team (MDT)
The MDT at Rowanbank clinic is well resourced and includes nursing, psychiatry, psychology, pharmacy and allied health professionals. Regular MDT meetings ensured that all professionals, individuals, and relatives were aware of what care was planned.

Each consultant psychiatrist for the various wards held a weekly MDT meeting. Each member of the MDT provided care and treatment specific to their expertise and provided weekly feedback at the meetings. Individuals met with their key nurse before the meetings and discussed any issues, or questions they wanted to raise at the meetings. The meetings were recorded on a structured MDT meeting template which was held on EMIS. During this visit, we did not hear any issues or concerns from those that we spoke with about their attendance at the MDT meetings.

We found detailed recording of the MDT discussions, decisions and personalised care planning for individuals. We were pleased to see clear links between MDT discussions and the care plan outcomes, as well as evidence that individuals were making progress and moving towards achieving the aims and goals of the admission. The records we reviewed covered a wide range of relevant information on a range of actions and goals to be achieved in a specified time frame, including physical health monitoring, reviews of medication and medication changes, reference to the appropriate risk assessments and when mental health and capacity legislation required reviewing.

We found evidence that delayed discharges and those subject to excessive security appeals were discussed at MDT and CPA meetings. The exact number of individuals waiting on a move to a lower level of security changes regularly. We heard this could be a challenge and people were delayed for prolonged periods of time and were in hospital for months and years longer than needed due to difficulties in securing suitable high, medium and low secure placements. Hospital managers informed us that they felt unable to influence this due to the lack of suitable secure beds inside and outside the health board area.

Of those individuals who were in the hospital at the time of our visit, we were told that 21 could have had their care needs met in a more suitable environment. We continue to monitor these people to ensure that services, their psychiatrist, mental health officers and various managers are taking all reasonable steps to prioritise their discharge.

There is a service level agreement with a local GP surgery who provided input to the service. This also meant that the service could access other primary care services, as required. Managers advised us that meetings occur with the GP surgery management team every 3 months to address any issues. The surgery recently employed a female advanced nurse practitioner who is helping with individuals in

Sycamore and Elder. This new provision has helped to provide well woman clinics and ease of access to discuss female specific health needs.

Use of mental health and incapacity legislation

Individuals at the clinic are subject to restrictions of medium security; all patients require to be detained either under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act).

The individuals we met with during our visit had a clear understanding of their detained status. All individuals that we met with, where applicable, reported that they had advocacy support and legal representation. We saw regular involvement from advocacy in people's care records and heard from individuals how they valued this. We received comments from individuals, "I know my rights", "I have a solicitor and know how to appeal", "advocacy are easy to reach" and "advocacy are helpful".

All documentation relating to the Mental Health Act, the Criminal Procedure Act, and Adults with Incapacity (Scotland) Act, 2000 (AWI Act), including certificates around capacity to consent to treatment, were in place in the paper files and were up to date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Medication was recorded on the hospital electronic prescription management application (HePMA) and replicated what was recorded on the consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act.

We found a number of T2 and T3 forms that required reviewing as the medication was no longer prescribed. This was shared with the individual clinicians who agreed to address these matters. The rest of the forms that we reviewed were completed by the responsible medical officer (RMO) and were found to be up to date.

Any individual who receives treatment under the Mental Health Act or the Criminal Procedure Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this in their file. We gathered comments from individuals who stated, "my mum is my named person, she is scared to visit the clinic but calls regularly" and "it's my dad, he's able to speak up and go along to any tribunals". Many of the individuals in the clinic have no named persons or nearest relatives who are willing to engage with the service about their relatives' care.

For those people that were under the Adults with incapacity (Scotland) Act, 2000 (the AWI Act) we found documentation, including powers granted and details of proxy

decision makers. Where an adult does not have capacity in relation to any welfare or financial decisions, such as agreeing to medical treatment, care and/or support, the need for legal safeguards should be fully considered by the MDT to ensure rights are protected. This may include the need for a section 47 certificate, a power of attorney or guardianship order, complete with a clear recording of discussion, agreed actions and review. We found that all the relevant paperwork was in place and in order.

During our last visit we found confusion from staff surrounding the recording of which section of the AWI Act was used. We were pleased to see that this had improved for this visit. To aid staff, the Commission has worked jointly with NHS Education for Scotland (NES) to develop training in relation to the AWI Act and an eLearning module has recently been launched on TURAS. This can be accessed by anyone in the workforce and has been developed for those working with people aged 16+ years who may be considered to lack capacity to make some or all decisions

Rights and restrictions

Due to its medium secure status, Rowanbank Clinic operates a locked front door to the reception area of the building, along with an airport-style security checks for all visitors. All wards operate a locked door policy which is commensurate with the level of risk identified with the individual group.

Some of the individuals we met with were subject to enhanced levels of observation and were being cared for in their bedrooms, for the safety of themselves or others. All the observations that we witnessed on the day of our visit were being delivered in line with good practice.

Some individuals in the clinic are subject to levels of soft mechanical restraint (SMR). The Commission is required to be informed of all use of SMR, and we reminded the service to maintain these notifications.

Since our last visit, there is one individual who is subject to seclusion. Currently the clinic does not have a specifically designed seclusion room with cameras. Despite this staff and management have been working to ensure that the use of seclusion is being used for as short a period as possible. The individual's family have been contacted by staff to ensure that they are aware of this level of restriction. The use of seclusion for this individual has been shown to minimise incidents of harm to them as well as to staff.

We have requested that the Commission be kept informed of all use of seclusion in the clinic, and we reminded the service to maintain the rights and dignity of any individual subject to these measures. There has been a feasibility study undertaken into the introduction of two new seclusion suits in Sycamore and Hazel. Managers for the clinic are awaiting a decision on whether there is a budget available for this

work to commence. If agreed, patients will move wards to meet the needs of the individuals involved. We requested to be kept informed if this work progresses.

Advocacy in the clinic is provided by Circles Advocacy. The feedback on the advocacy service was very positive and this was noted during several of our meetings with individuals. The consistent input from advocacy to the clinic was noted at various meetings held throughout the service. We met with the advocacy manager and heard that the service continues to be well-used and valued service. We saw from the care records that advocacy attended the ward regularly and supported individuals who were involved in tribunals, in their discharge planning and at CPA meetings.

When we are reviewing individuals' records, 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. On this visit we found that where appropriate, advance statements were in place, and where individuals had completed advance statements, these were easily accessible. We found evidence that for those who had declined to complete an advance statement, this was documented and revisited at CPA meetings.

The Commission has regularly highlighted the significant difficulties with regard to 'individual flow' across the forensic estate. The situation of individuals in the hospital awaiting moves to lower levels of security remains an issue that continues to be addressed by Scottish Government and the Forensic Network in terms of a capacity review. The Commission has produced *Appeals against detentions in conditions of excessive security* good practice guidance which can help individuals, their named person, relatives and staff navigate this complex area.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals have their human rights respected at key points in their treatment.

Activity and occupation

We were pleased to find that there remains a strong focus on activity in the Clinic, supported by the occupational therapists (OT) and nursing staff.

From those that we spoke with, we heard that they were encouraged to participate in a variety of activities, in and outside of the Clinic. As the clinic is a medium security facility, most of the activity for individuals takes place in the clinic. Most individuals we met with had free access to the enclosed clinic grounds and were able to join in activities such as football, gardening, gym and attendance at the community centre. On-ward activities were mainly led by OT and nursing staff and included a mixture of

one-to-one and small group activities. We observed activities while visiting the wards, which included newspaper groups, card and board games.

We received comments from individuals in Sycamore regarding the lack of access to a rehabilitation kitchen in their ward. The individuals were required to use the kitchen in another ward adjacent to Sycamore. Those who we spoke with praised the benefits of the cooking groups in the clinic. This allows individuals to purchase food and cook meals from fresh, with a specific focus on recovery and development of life skills.

During this visit we did not visit the community centre. This resource provides individuals with a variety of activities including access to the gym, prayer room, activities room, café, sports hall, meeting room, library, computer room and the communal space. Similar to our last visit the centre, we heard positive feedback about this resource from the individuals we met with.

We heard about the flexibility in finding activities that matched with individuals' interests. We observed individuals working in the clinic's greenhouse, which is managed by the OT service. We were pleased to find each individual, even those who were most unwell, had a timetable that recorded a programme of activities related to their interests, assessed needs, goals and outcomes. We heard from individuals that the lots of work was undertaken by OT and nursing staff to engage with them in a person-centred approach.

We heard about the support being supplied by Glasgow City College and Rosemount Lifelong Learning to improve adult literacy. These services have supplied access for individuals to their library and other resource areas. Individuals in Larch spoke of their opportunity to undertake Scottish Vocational Qualifications (SVQ's) which they described as "great" and we noted was a great asset for those in the service.

We heard from managers about a two-week community football pilot project working across the low and medium wards to promote exercise and positive mental wellbeing.

We did not hear of any significant gaps in activities from those with whom we met.

The physical environment

The clinic is a purpose-built medium secure forensic facility. The physical environment is largely similar to that which has been detailed in previous visits.

Each ward had a communal area that had a TV, soft furnishings and decoration to make it more homely. We did not hear from any individuals of concerns regarding the environment.

We found some of the wards to be bright and clean while others were found to be tired and in need of improvements, specifically Larch, Holly, Elder and Sycamore. We observed concerns regarding the condition of paint work in a number of the wards. This included the low stimulus room in Sycamore.

There was a need to upgrade carpeting in Holly Ward due to stains and wear and tear.

A number of the day room chairs were found to be tired and in need of replacing. We found doors missing from some of the rooms in the ward.

We raised that due to the length of time many individuals find themselves confined to the clinic these environmental improvements require to be prioritised for their benefit.

Recommendation 3:
Managers should ensure a programme of work, with identified timescales, to address the various environmental issues.

Other comments

We were informed by managers of a new practice development post for the Clinic. This role commenced in January 2025 with a specific focus on ensuring staff feel supported and valued as part of the service. The role involves providing training on ASSIST, STORM, support for newly qualified nursing staff and allows staff to self-refer for support.

The post includes the reintroduction of Behavioural Family Therapy which is to commence for individuals and their families in July 2025. We look forward to hearing about the impact of this on individuals and their families during our next visit.

We also heard that the staff in Elder ward were winners of a regional service award for Team of the Year in 2024. As there is currently no high secure female service in Scotland, the team were recognised for providing individualised and innovative practice for women. The award pointed out the extensive work undertaken to adapt the ward environment, including the incorporation of a therapeutic garden that involved the individuals, who would be using this space, in the design of it. The outcome of these various steps have helped to reduce the level of assaultive behaviours and improved the quality of life for the individuals in Elder ward.

Summary of recommendations

Recommendation 1:
Managers should urgently seek to address the extensive concerns raised about the food provided.

Recommendation 2:
Managers should take steps to ensure that a financial care plan is in place for all those subject to these measures.

Recommendation 3:
Managers should ensure a programme of work, with identified timescales, to address the various environmental issues.

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.

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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