Mental Welfare Commission for Scotland

Report on announced visit to:
Blythswood House, now Munro Ward, Stobhill Hospital, 133 Balornock Road, Glasgow, G21 3UW

Date of visit: 8 October 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

Blythswood House provides assessment and treatment for adults with learning disability and mental ill health. The service moved to Munro Ward at Stobhill Hospital from its location in Renfrew earlier this year as Blythswood House had become uninhabitable due to damp. At the time of the move the numbers of beds in the service were reduced from 16 to nine.

We last visited this service in May 2024 and made recommendations about the environment and the building, which was not considered to be fit for purpose. We received a response from the service about the actions they would take, however, these recommendations are no longer relevant given the new location of the service.

On the day of this visit, there were nine people in the ward and no vacant beds. We wanted to see the new environment and how it was being used to meet the needs of the people in the service, as well as hearing from people about their care and treatment.

Who we met with

We met with, and reviewed the care of nine people, six who we met with in person and nine who we reviewed the care notes of. No relatives asked to meet with us on the day of our visit.

We spoke with the service manager, the senior charge nurse, nursing and healthcare support staff, the lead occupational therapist and one of the consultant psychiatrists.

Commission visitors

Mary Hattie, nursing officer

Dr Sheena Jones, consultant psychiatrist

Dr Rachael Lee, specialist registrar

What people told us and what we found

The ward was busy when we visited. We saw people taking part in sensory and singing group activities with a lot of enjoyment. We saw people engaging in activities of their choice with support from staff on an individual basis. We also saw people going out with staff to do things in the community.

Many of the people we met with were unable to tell us what they thought about their care and treatment. Some people did talk to us about things that were important to them, including their hobbies, their families and their hopes for the future. We saw that people were receiving compassionate care with positive interactions with the staff team. It was evident the staff team knew the people in the ward well and were able to support us to interact and communicate with people during our visit.

Where people were able to tell us about their care and treatment, we heard that the staff team were kind and helped them.

When we asked people about being in Munro Ward, we were told that it was a good place and people enjoyed being with everyone else.

Care, treatment, support, and participation

Care records

We reviewed care records on the electronic EMIS system. We were also able to review key pieces of information and care plans that were kept in a paper folder in the ward. We also reviewed people's medication charts on the electronic HEPMA prescribing system.

We found that there was a wide range of information available about each person. The information covered all aspects of their physical and mental health and included 'All About Me', along with information about each person's background and documentation to support people when they have to attend appointments or hospital for physical health care.

We reviewed care plans in paper and electronic format and saw that they provided a range of up-to-date information about each person's holistic care and support needs. The care plans were regularly reviewed and updated.

We saw that people's views were included in their care records and care plans and that there was regular communication with relatives and carers to involve them in treatment decisions. We also saw examples of easy read care plans to support people to have information about their care in a way that was meaningful for them.

There was a range of information available for each person to support and document risk assessment and management approaches that covered a broad range of physical, mental and developmental care and support needs. These were

person-centred and linked with care plans, multidisciplinary meetings and positive behaviour support plans.

Multidisciplinary team (MDT)
The multidisciplinary team in Blythswood House is well resourced and the service has benefitted from the redeployment of staff following the closure of a local long stay service. The reduction in bed numbers in the service has further improved staffing levels.

The nursing team is led by a senior charge nurse and there are also three charge nurses in post. There has been ongoing recruitment with two newly qualified nurses joining the team and no gaps in staff nurse or healthcare support worker teams.

There is a daily 'huddle' meeting which ensures that there is adequate staff to meet the needs of people in Blythswood House and the Claythorn Unit at Gartnavel Royal Hospital depending on levels of distress and activity in the two services at that time. We also heard that since the Blythswood service relocated from the community to a hospital site, it has been able to provide care and treatment for people with more acute needs and this increases the flexibility of both services when meeting the needs of individuals.

A local GP practice visits the service twice weekly and has oversight of people's physical health. We saw detailed information about people's physical health.

The move to the Stobhill Hospital site means the service can access the duty doctor service that is available in the mental health wards, and which provides urgent care out of hours. The service can also access an emergency response from the other mental health wards using the emergency alarm system should there be a significant incident in the ward.

We spoke with the lead occupational therapist (OT) and heard about their open referral system. We heard that the OT pathway had been redeveloped and a move towards a model of care that supports people to maintain established skills when they are admitted to hospital as well as a focus on skill development. We also heard about the ongoing work to ensure that people's sensory needs were understood and sensory integration training for the OT team.

We heard from various members of the multidisciplinary team about the work that had been happening to plan people's admissions from before they were admitted to hospital. This approach allows everyone involved in a person's care to consider what the goals of admission would be and ensure that the care plans to support this were in place before admission to hospital, where possible.

We heard that the speech and language therapy provision in the ward has been increased since our last visit. We saw helpful easy read and accessible information

in people's care plans and in the ward, in addition to communication profiles in people's care records.

We heard that in addition to the psychology input to the service that the professional lead psychologist post had recently been filled. We saw detailed positive behaviour support plans in people's care records which supported people and their care teams to understand and support individuals.

The multidisciplinary team also included three consultant psychiatrists, physiotherapy and access to dietetics.

MDT meetings

We reviewed the minutes from the MDT meetings that took place in the ward. The frequency of these meetings could vary depending on the stage of each individual's care and treatment from weekly to monthly.

The service has an extremely detailed and comprehensive MDT meeting template which is updated for every meeting. The MDT meeting document covered all relevant aspects of a person's care and treatment, and we saw that these provided a very helpful account of each person's care and treatment, their progress and the actions of the multidisciplinary team.

We saw that the information recorded in the MDT meeting minutes was relevant, current and in relation to a wide range of identified needs.

We saw that the views of people, their families and carers were included and that people, their families and carers could attend the meetings as they wished.

We saw that other relevant professionals were also involved in the meetings, as appropriate to each individual and included advocacy services, the social work teams and community support organisations.

We also noted that one section of the MDT template allowed staff to identify areas that would be helpful to consider in supervision, supporting the reflective practice approach taken by the service.

Delayed discharges

We heard from senior staff members about progress made over the last year to support people to leave hospital and live with the appropriate level of support in the community. A number of people had also had their discharge facilitated at the time that the service had to move to its new location.

When people are ready to leave hospital and there is no appropriate community service for them, then they are considered to be a "delayed discharge". At the time of our visit to Blythswood House there were three people who were considered to be a delayed discharge who did not have any discharge plan in place. In each of these

cases we have made enquiries with the relevant local authority and will continue to follow this up.

Use of mental health and incapacity legislation

On the day of the visit, nine people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment were available in the individuals' electronic records and in the paper files.

All paperwork relating to the Mental Health Act was reviewed and was up-to-date and correct.

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. All nine people had a certificate authorising treatment (T3) under the Mental Health Act in place where required. All treatments that were prescribed corresponded to the medication authorised in the T3 except in one case where a higher dosage of medication was in use than was authorised. This was raised with the relevant RMO and action was taken at the time of our visit.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We did not see any documentation in relation to the nomination of a named person which is in keeping with the significant cognitive and communication needs of the people in the service.

For those people that were subject to the AWI Act, we found all the relevant welfare guardianship documentation detailing the powers that were in place in each person's records.

Where people were subject to financial powers, we saw documentation about their capacity and care plans in relation to their spending and access to money to support their activities in the community.

In one case, a person's spending plan included budgeting for their cigarette use. We raised this with the service on the day and heard about the efforts that had been made to help them reduce their cigarette use. We also spoke about the person being able to access the garden area to smoke and were told that this had been assessed and was considered necessary due to the person's recurrent attempts to abscond. At the time of our visit, we advised that smoking on the hospital site is contrary to the smoke free hospital legislation. We look forward to hearing how this situation is resolved.

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. We reviewed section 47 certificates and the associated care plans and found them to contain up to date information about people's physical health and treatment.

Rights and restrictions

Blythswood House operates a locked door policy, and we saw that, where appropriate, this was discussed with people when they were admitted to the service.

The majority of people in the service had increased levels of support from nursing staff. This is also called "continuous intervention". Where continuous interventions are in use, there is a care plan in place which details the purpose and the form of the continuous intervention. In other cases, people had continuous interventions to reduce the risk of self-injury or to respond when a person was becoming distressed. Some people could become agitated, aggressive or display sexual behaviours towards others and required continuous interventions to ensure that everyone was safe. We also noted that one-to-one care was provided where required to support people's physical health when they were at risk of choking, seizures and falls.

We reviewed the care plans for continuous interventions and for time people spent out with the service; we found them to be person-centred, relevant to the person's identified care and support needs and they took the least restrictive approach. Continuous interventions were regularly reviewed and where possible, reduced to minimise the impact on the individual.

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 a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found that the documentation was available, updated and regularly reviewed.

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 advance statements which was in keeping with the assessed cognitive and communication needs of the people in the ward.

Activity and occupation

We heard, at the time of our previous visit, about the work undertaken by the multidisciplinary team in relation to prioritising activities for people in the ward and the benefits that had resulted from this.

When we visited the service this time, we saw timetables for activities in the ward displayed on the noticeboard. We saw people engaging in activities in the ward and the range of activities that people had in their own rooms, should they wish.

We heard that people had their own individual timetables for activity and saw people going out of the ward to take part in a range of activities with staff, their families and with community organisations.

We also heard from the lead OT that people can access community support and activity organisations such as Project Ability, Theatre Nemo, and the "I Can Do" project. We heard that taking part in community activities, which people can continue to attend after they have moved into the community, supported transition from hospital and helped people to establish a range of activities that they could continue to attend.

The physical environment

We heard from the multidisciplinary team that there had been little time to prepare people for the move to Munro House, however, the move had gone well and there were a lot of positives about the new ward environment.

This included the benefit of a single staff team providing care and treatment for people in one larger area (as opposed to three individual units in the previous location) which has increased everyone's safety and enabled people to join in the activities when they see what is happening.

We were told that one disadvantage of the move has been an increase in noise in the service, however, there are a number of different lounge and activity spaces available for people which we saw being used by everyone to take part in activities with staff and in groups. There was also the opportunity for people to go out into the community to take part in activities there.

Munro Ward is a large, bright unit which has wide corridors and plenty of natural light. It was clean and bright with pictures on the walls about recent activity projects involving everyone in the ward. We saw information displayed about our visit on the walls in addition to an easy read version of our previous visit report displayed in the main corridor.

The ward has been adapted to meet the needs of the people in the service. This has included the creation of a sensory room with beanbags and comfortable chairs, lights and sand pit.

The are six bedrooms in the unit which are small, clean and well-furnished with en-suite facilities. We could see that people had their own decorations, possessions and activities in their rooms when they wanted them.

In addition to the bedrooms, there were three large dormitory spaces that had been adapted into individual living areas for three people who benefitted from the additional space. These areas included a bedroom area, a living area and activities which reflected the needs and preferences of each individual.

For each person we could see that the “What Matters to Me” information was available on the door of their room.

Some people in the ward needed additional privacy in their bedrooms and to ensure their dignity. We saw that some people had plastic film over part of their window for this reason. The film had a floral design and was used only on the lower part of the window so that people could still see outside. For others blackout blinds could be placed over the outside of the window where it was necessary to ensure their privacy.

There is an enclosed garden space to the rear of the ward which has been decorated with planters, which people can use for activities and to have outdoor access.

The ward does not have an adapted kitchen to support people to gain skills in activities of daily living (or ‘ADL kitchen’). We heard that there was a pantry area that could be used for skills which did not require an oven etc. The ADL session had continued to be offered. We were pleased to hear on the day of our visit that that it had been agreed that an adjacent ADL kitchen could be accessed by the service to support people in skills development.

Any other comments

We heard from the service manager and senior staff about two recent events that brought together community and inpatient teams alongside commissioning services to develop a shared understanding of people’s respective roles, outreach services, criteria for admission and care planning when admission was being considered. These events had been well attended and were supporting development of a nursing pathway that would identify when the community team might involve the inpatient team, and vice versa, to provide outreach or support with discharge planning etc.

We were told about ongoing work to review the debrief and reflective practice models in the service in response to a previous significant adverse event review.

We also heard about ongoing work to collect meaningful data about the use of restraint and seclusion in the service with the development of a checklist aimed at reducing the use of restrictive practice.

We were pleased to hear about the intention to involve people in the service when considering strategies to reduce the use of restrictive interventions and look forward to hearing of progress with this.

We heard from senior management about the importance of staff being able to attend training in relation to key learning and that there had been recent opportunities for staff to improve their understanding of restrictive interventions.

We heard about the intention to undertake a pilot project in both Blythswood and Claythorn Units to review care plans for people where there are significant restrictions in place. The process will include a multidisciplinary review of people's restrictive care plans with the involvement of individuals and a review of the effectiveness of the new care plans after a period of time. It was positive to hear the intention to give people more opportunity to be involved in their care and we look forward to hearing of progress with this.

Summary of recommendations

The Commission made no recommendations; therefore no response is required.

We would 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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