Mental Welfare Commission for Scotland

Report on unannounced visit to:
Henderson Ward, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

Date of visit: 27 November 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

Henderson Ward is a 20-bedded unit in Gartnavel Hospital that provides acute mental health admission for individuals.

On the day of our visit, there were 20 people on the ward and no vacant beds.

We last visited this service in April 2024 on an announced visit and made recommendations in relation to a protocol for individuals who were boarding out of their catchment area, as well as consent to treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

The response we received from the service was that the policy and procedure had been updated in relation to individuals who were boarding out and audits of consent to treatment certificates were routinely undertaken.

On the day of this visit, we wanted look at issues that had an impact on care and treatment, including the implementation of the updated policy and procedure in relation to risk assessment and communication with families and/or unpaid carers.

Who we met with

We met with five people and reviewed the care for four of these individuals. We reviewed the care notes of a further two individuals. No relatives wished to speak with us on the day of our visit.

We spoke with the charge nurse (CN) and staff nurse (SN).

Commission visitors

Gemma Maguire, social work officer

Denise McLellan, nursing officer

Alison Thomson, nursing officer

What people told us and what we found

Individuals we met with told us staff were “nice” and how they felt “better supported here” compared with other inpatient services. We heard how people felt “listened” to by nursing staff, the consultant psychiatrists (CPs) and social work staff.

On the day of our visit, we observed staff to interact with individuals on Henderson Ward with warmth and compassion. We found that despite many people experiencing acute mental illness and at times distress, the trauma informed approach taken by staff helped people to feel safe and helped create a calm environment throughout the day.

We heard from staff and individuals we met with how the service valued communication with family and/or unpaid carers. We found that views from individuals, family and/or unpaid carers were consistently recorded in individual care plans and were also being considered by the MDT when decisions were made about care and treatment.

We met with the CN and SN separately and heard how the staff team, including members from the multidisciplinary team (MDT), had good communication with each other. We were also advised that the support provided by managers and colleagues, had ensured staff felt ‘valued’ and motivated.

We were advised by the CN that consistent social work input to the MDT meetings had helped to progress social work assessments and/or legal safeguards, including welfare guardianship orders to prevent unnecessary delays in discharge planning. Individuals we met with spoke positively about social work input on the ward.

Care, treatment, support, and participation

Care records

Care plans we reviewed on the day of our visit covered individual needs in relation to physical and mental health. We were pleased to find that care plans recorded the views of individuals, family and/ or unpaid carers and they evidenced meaningful consultation in line with local policies and procedures.

Care plan reviews were being carried out weekly, where nursing staff met with people to discuss the progress they had made towards agreed goals. We were also pleased to find that actions were being addressed in the care plan review that linked with MDT records and risk assessments.

Some people we met with on the day of the visit were unaware they had a written care plan document. We discussed this with the CN and advised that plans should be shared and signed by individuals. We further advised that when someone was unable to sign and/or chose not to sign their care plan, this should have been clearly documented in their care record.

Recommendation 1:
Managers responsible for Henderson Ward should ensure that person-centred care plans are shared and signed by individuals. Where someone is unable to sign and/or chooses not to, this should be clearly recorded.

We are pleased to find that risk documentation was in line with the local policy and procedure. We found that the risk assessment records included historical information, were reviewed and had clear, individualised details on how each risk should be managed.

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.

Multidisciplinary team (MDT)
Henderson Ward MDT consisted of nursing staff, CPs, junior doctors, pharmacy, occupational therapy (OT), psychology and social work. Referrals can also be made to other services, such as physiotherapy and speech and language therapy.

We found that MDT meetings happened weekly, with a record of who attended meetings. We were pleased to find that MDT records had clear action points relating to the person-centred care plans and risk assessments. We also found that individuals and/or their family were invited to attend meetings and their views noted in the record of the meeting.

Use of mental health and incapacity legislation

On the day of the visit, 15 people were detained under the Mental Health Act. All individuals detained were aware of their rights. Several individuals were receiving legal advice and accessing advocacy services.

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. Consent to treatment certificates (T2) were in place and corresponded with the medication that had been prescribed. We found that one person did not have all the prescribed medication on a certificate authorising their treatment (T3) under the Mental Health Act. This was highlighted to the CP, who took action to rectify this.

Recommendation 2:
Nursing and medical staff on Henderson Ward should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

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

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. There were a number of individuals who had nominated a named person; we found documentation for this to be accessible and the named person had been appropriately consulted.

For people we met with and/or reviewed who were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), we are pleased to find that care records had clear and accessible information about the guardianship order or power of attorney documentation regarding welfare and financial decisions.

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. Two individuals that we reviewed on the day of the visit had section 47 certificates in place.

Rights and restrictions

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 a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit, no one on Henderson Ward was specified under the Mental Health Act.

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 reviewed the care records for one person who had an advance statement in place.

The template used by the service to record MDT meetings referred to advance statements, but there was no evidence that meaningful discussions were taking place with individuals about completing and/or reviewing statements during these meetings. We discussed this with the CN on the day of our visit and agreed that the MDT template already in place provided an opportunity to promote the benefits of advance statements and/or to review statements already in place. We look forward to seeing progress in this area on future visits to Henderson Ward.

Activity and occupation

During our visit to Henderson Ward, we heard from individuals and nursing staff how they valued the role of patient activity (PAC) nurse. We were told that the PAC nurse has helped to ensure activities were meaningful, with individuals and staff being

involved in the planning of activities. Despite the PAC nurse being on an extended period of leave at the time of our visit, individuals were continuing to undertake occupational and therapeutic activities.

Activities included relaxation and wellbeing groups, walking, art and pet therapy, as well as art and crafts. Several individuals were involved with OT services who were undertaking functional assessments to support discharge planning.

We were shown the ward activity room, which was a well-used, colourful space with artwork displays, games and music. One individual told us how the room provided 'character' to the ward and that people worked together to decorate the ward for the festive period.

One individual with complex needs was waiting for a bed in a specialist service and was subject to continuous intervention (CI). CI can be a therapeutic intervention provided to individuals who are acutely unwell and require a higher level of staff observation to ensure safety. We were pleased to find this person was being supported with an individualised activity plan which included a treadmill and punch bag that had been set up in a small quiet lounge area of the ward. We heard how this has supported the person to exercise safely while regulating their emotions, reducing the need for more restrictive interventions, including use of physical restraint.

The physical environment

The ward was bright and spacious with rooms that were used for therapeutic activities, receiving visitors, TV/Lounge and dining areas.

All bedrooms are ensuite, and individuals can access a large outdoor garden area. Part of the garden is not visible from the entry/exit door and people can easily climb over a fence should they wish to leave. The Commission understood that for many individuals on Henderson Ward, the large garden area is beneficial to their recovery, and they do not require continual supervision and/or restrictions to be imposed.

We discussed with the CN how staff manage risk in relation to individuals who were likely to abscond from the garden and where restrictions were in place to protect them and/or others. We were advised that individual risk assessments were carried out and reviewed, with staff supervising people in the garden when required. On the day of our visit, there were no concerns raised by anyone in relation to accessing the garden. We observed appropriate supervision by staff in the garden area for individuals who were assessed to require this.

We were pleased to learn that Henderson Ward has shared access to a family room which was used to support visits between individuals and their children. We found the room to be sparse in appearance and discussed this with nursing staff as to how improvements to the décor and facilities could improve the environment so that it

was supportive for children when visiting family members. We look forward to seeing improvements here on future visits.

Individuals and staff informed us that many people use the garden area to smoke. The Commission is clear that smoking on hospital grounds is an offence, with individuals being at risk of penalty notices and fines. While the Commission understands that individuals may experience difficulties in relation to nicotine withdrawal, we are aware that other acute adult admission services are effectively managing smoking bans and utilising nicotine replacement and support services.

We would encourage NHS Greater Glasgow and Clyde (NHS GGC) managers to ensure staff have clear guidance regarding implementation of the smoking ban. The Commission continue to escalate these concerns with NHS GGC managers.

Recommendation 3:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

Summary of recommendations

Recommendation 1:
Managers responsible for Henderson ward should ensure that person centred care plans are shared and signed by individuals. Where someone is unable to sign and/or chooses not to sign, this should be clearly recorded.

Recommendation 2:
Nursing and medical staff on Henderson Ward should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

Recommendation 3:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

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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