Mental Welfare Commission for Scotland

Report on unannounced visit to:
Armadale Ward, Stobhill Hospital, 133 Balornock Road, Glasgow G21 3UZ

Date of visit: 16 December 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

Armadale Ward is a 20-bedded unit in Stobhill Hospital that provides acute mental health admission for 16 individuals, with four beds reserved for the inpatient eating disorder service.

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

We last visited this service in November 2024 on an announced visit and made recommendations in relation to recording systems for person-centred care plans, providing information on the rights of individuals who are admitted on an informal basis, access to bedrooms and hospitals being smoke free.

The response we received from the service was that care plan recording systems were being reviewed by practice leads and that individuals are provided with information about their rights when admitted to the service on an informal basis. We were informed that the service continues to lock bedroom doors during certain periods to manage risk, safeguard people's valuables and to encourage therapeutic engagement. We were also advised that staff would continue to inform individuals that smoking in hospitals was now illegal.

On the day of this visit, we wanted look at the progress made by service in addressing previous recommendations, as well as any other issues that has an impact on care and treatment.

Who we met with

We met with three people and reviewed the care for these individuals; we reviewed the care notes of another two individuals. We spoke with one relative on the day of our visit.

We spoke with the charge nurse (CN), the therapeutic activity nurse (TAN), the operational lead (OL) and the service manager (SM).

Commission visitors

Gemma Maguire, social work officer

Mary Hattie, nursing officer

Laura Young, nursing officer

What people told us and what we found

People we met with told us staff were “lovely” and “caring”. Two individuals reported to feel that some staff did not listen to their views and the focus of their care and treatment was to “comply”.

Some people involved with the eating disorder service felt there was a lack of therapeutic interventions available on the ward, reporting that access to psychology could feel “disjointed”. When reviewing care records, we found evidence of one-to-one psychology input being provided by the eating disorder service. However, we did not find evidence that psychological based approaches were being used to inform risk assessment, person-centred care planning and/or continuous interventions (CI).

The local policy and procedure in relation to CI is clear that therapeutic interventions should be provided to individuals who are acutely unwell and require a higher level of staff observation to ensure safety. We discussed the above issues with the SM, the CN and the OL on the day of our visit and were informed that the CI policy has been rolled out since our last visit. We heard how the service provides training and supervision to support staff and that the audit of records was carried out to ensure that the CI policy was embedded in practice. We were also advised by the SM that psychology input for individuals with an eating disorder would be discussed and reviewed with the wider multidisciplinary team (MDT).

As noted from previous visits to the service, we continue to hear from individuals, managers and staff about various challenges in providing an eating disorder service that is co-located in an acute adult mental health service. We heard how managing the varied and often complex needs continues to be difficult. We have previously been informed that discussions had taken place with senior managers regarding these concerns. We were disappointed to hear that no progress has been made in terms of resolving these concerns. We will continue to follow up this issue with the service managers.

We spoke with a family member who informed us that staff were “great” with their loved one however they felt communication with the MDT, including social work and consultant psychiatrist was, at times, inconsistent.

When reviewing care records, we did not find evidence that family and/or unpaid carers were consistently being consulted in relation to their loved one’s care. NHS Greater Glasgow & Clyde (NHS GGC) have developed clear guidance for staff around communication with families and/or unpaid carers, and we would encourage managers to ensure this is embedded in practice.

We were advised that Armadale Ward will be temporarily decanted in the coming months to allow necessary health and safety work to be carried out.

Care records
We reviewed the care plans on the day of our visit and found there were inconsistencies in the quality of recording; some did not fully address the needs of individuals. We found that some people had been identified as being at risk of self-harm, however this was not adequately addressed and/or information was missing from their care plan.

Some people told us that they had a named nurse who they met with, but they were unaware of what information was written in their care plans. We did not find evidence that plans were being shared with and/or signed by individuals.

We found that care plan reviews were not happening consistently, with some plans not being reviewed for several months.

Recommendation 1:
Managers should audit person centred care plans to ensure they address all individual needs and that progress made towards identified goals are consistently reviewed.

Recommendation 2:
Managers should ensure that care plans are shared and signed by individuals. Where someone is unable to sign and/or refuses to sign this should be clearly recorded.

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 found individuals had risk assessment documents in place, with some detail around historical information. However, we noted several documents had not been reviewed and/or updated to include risks which were identified in other care records. We also found that risk assessment documents lacked detail on how staff could support individuals to manage risk to themselves and/or others.

Recommendation 3:
Managers responsible for Armadale Ward should audit risk assessment documentation to ensure they are reviewed, with information provided on how each risk should be managed.

We noted that some care plans and/or risk assessment documents did not record the views of individuals' and/or their families. We provided advice to the SM, the CN

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

and the OL on the day of the visit to ensure that individuals and/or their families were consulted, with their views clearly recorded.

Recommendation 4:
Managers responsible for Armadale Ward should audit all care records to ensure individuals and their families are being appropriately consulted with their views clearly recorded.

Multidisciplinary team (MDT)
The MDT on Armadale Ward consists of consultant psychiatry, junior doctors, nursing staff, TAN, psychology, OT, pharmacy and dietician.

At the time of our last visit to the service, we reported that MDT records related to person-centred care plans, with a clear record of actions and decisions being made. During this visit we found some good MDT records with clear actions, however this was not consistent. Some records lacked detail of who attended, what was discussed and/or any actions agreed. We discussed this with the CN, the SM and the OL on the day of our visit and were advised the service were aware of these inconsistencies and the issues had been raised with disciplines in the MDT.

Recommendation 5:
Managers in Armadale Ward should audit MDT records to ensure discussions and agreed actions which relate to individualised goals are consistently recorded and acted upon.

Use of mental health and incapacity legislation

On the day of the visit, 11 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All individuals detained under the Mental Health Act were aware of their rights. Several individuals had nominated a named person, 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. We found two people did not have all their prescribed medication included on their T2 consent to treatment certificate, and there was not a T3 certificate authorising this medication under the Mental Health Act. This was highlighted to the CN, the SM and the OL for action on the day of our visit.

Recommendation 6:
Nursing and medical staff on Armadale Ward should ensure that all prescribed medication for detained individuals is appropriately authorised under the Mental Health Act.

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. Where a patient had nominated a named person, we found documentation to be accessible and the named person to be 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 guardianship orders or power of attorney documents 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. On the day of the visit, none of the individuals we reviewed had, or required, a section 47 certificate to be 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 two people on Armadale ward were specified under the Mental Health Act.

For one individual we found that the relevant paperwork in relation to restrictions had been applied but not completed and no reasoned opinion had been provided. We also found that both individuals had not been notified in writing about restrictions in place, review timescales and of their rights. We fed this information back to CN, the OL and the SM on the day of our visit for action.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[2].

Recommendation 7:
When someone is made a specified person, medical staff in Armadale Ward should ensure appropriate notification paperwork is completed in relation to restrictions being implemented and record a reasoned opinion for imposing restrictions. Individuals should also be given written information regarding restrictions in place, timescales for review and information about their rights.

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

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.

On the day of our visit, of the care records we reviewed the care records, we did not find anyone 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 provides an opportunity to promote the benefits of advance statements and/or to review statements already in place. We look forward to seeing progress on future visits to Armadale Ward.

Individuals we met with on the day of our visit reported to find the locking of dormitory doors 'distressing' and that access had been refused even when they had been visibly upset, requiring them to remain in communal areas. Some people felt this was 'inhumane' particularly if they felt distressed and where they had no quiet areas they could access to protect their dignity. We discussed this with the CN, the OL and the SM and were advised that following on from our last visit to the service, the dormitory room doors have remained locked on specific days and times to encourage people to participate in therapeutic activity.

We heard that individuals could request access to their bedroom when required. The Commission were disappointed that the service has not acted on our previous recommendation to ensure that such restrictions are based on individual risk assessment. We are of the view that locking an individual's bedroom to encourage engagement in activity is overly restrictive and would urge managers to review this practice as a matter of priority.

Recommendation 8:
Managers for Armadale Ward should ensure that a person's access to their bedroom, including shared dormitories, is not restricted unless legally authorised and based on individual risk assessment.

We continued to find concerns during this visit in relation rights-based practice for individuals who are admitted to the service on an informal basis. One individual we met with was admitted to Armadale Ward on an informal basis and they told us that they were unaware that they could leave the ward, and hospital grounds, if they chose to do so. They informed us that if they had not agreed to being admitted to Armadale Ward, they would have been detained. They also reported that no

information had been provided about their rights upon admission, and that they were not permitted to leave the ward unless being accompanied by ward staff or a relative.

We reviewed the care records for this individual and did not find any evidence that information regarding their rights had been discussed with them during their admission. We escalated this concern to the CN, the SM and the OL on the day of our visit, recommending the person was informed of their rights. We also advised that where there are concerns around consent, capacity and/or risk, a consultant psychiatrist should review the need for safeguards under the Mental Health Act as a matter of urgency.

Recommendation 9:
Managers should ensure individuals who are admitted informally to Armadale ward are fully advised of their rights, verbally and in writing. They should check individuals understand their rights when being asked to consent to recommended treatment, including being advised not to leave the ward/hospital.

During our visit we found that the keypad code for exiting the ward was not displayed anywhere in the corridor and/or communal areas. The CN and the SM advised that the code is usually displayed next to the keypad, however people often remove the code from the wall.

In discussion with the SM, they advised that while they do display the code on the wall, there is an increased risk that some individuals who are subject to restrictions may abscond from the ward and be placed at harm. It is the Commission's view that not displaying the door code is overly restrictive for individuals who are informal and/or do not have restrictions placed on their time out of the ward. Where individuals are subject to restrictions under the Mental Health Act and are assessed as being at risk if they left the ward, individualised care plans should be put in place to manage risk. The CN, the SM and the OL confirmed that arrangements would be made to ensure the door code was displayed on the wall.

Activity and occupation

During our visit to Armadale Ward, we met with the TAN and heard about the variety and range of activities on offer, including art groups, pet therapy and walking groups.

We were also pleased to hear about the links TAN service has developed with community voluntary projects to support individual occupational and vocational skills. The TAN also organises group outings in the community, having access to a minibus and arranges ward-based activities such as Karaoke.

Individuals we met with on Armadale ward described the TAN as "brilliant" and they valued the range of group and one to one activity the service offers. We heard from

some individuals that when the TAN nurse was absent for some weeks, there was nothing to do during this time.

We heard from the CN how the increasing demand and pressure on nursing staff to ensure risk is managed and clinical needs are met makes it challenging to support activity when the TAN is not available. We were advised that while the service has a full complement of nursing staff, there are shortages in relation health care support worker (HCSW) in the service. The SM advised that provision of HCSW is being considered by the service.

The physical environment

The layout of Armadale Ward consists of single ensuite rooms and shared dormitories. The environment was clean, with direct access to a well maintained garden area.

On the day of our visit, we observed individuals smoking cigarettes in the garden area. 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 GG&C managers to ensure staff have clear guidance regarding implementation of the smoking ban. The Commission will continue to escalate these concerns with NHS GG&C managers.

Recommendation 10:
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.

Any other comments

The Commission would urge managers to ensure recommendations in relation to person centred care planning, assessment/ management of risk, rights and restrictions are addressed as a matter of priority. We will continue to follow up on action plans being implemented by the service to address these issues.

Summary of recommendations

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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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