Mental Welfare Commission for Scotland

Report on unannounced visit to:
Portree Ward (IPCU) Stobhill Hospital, 133 Balornock Road, Glasgow, G21 3UZ

Date of visit: 25 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

Portree Ward is the intensive psychiatric care unit (IPCU) situated in McKinnon House at Stobhill Hospital.

This is a 12-bedded unit for people aged 18-65 that provides intensive care, treatment and interventions to those who present with an increased level of clinical risk and require an enhanced level of observation. IPCUs generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often distressed individuals.

The ward is a mixed-sex facility, providing three female beds and nine male beds, which were all single rooms with en-suite facilities.

Since our last visit, three beds in the ward have temporarily closed due to the heating system in the ward not working as intended. This has resulted in those bedrooms being deemed unsafe to use due to the lack of heating. On the day of the visit, there were nine individuals in the ward.

When we last visited this service, we made six recommendations. These were in relation to the availability of safety alarms for staff, that discharges were prioritised for those inappropriately placed in the ward, that paperwork relating to proxy decision making and section 47 certificates were recorded in the care records, that all individuals' dignity is prioritised when subject to direct observations and work should be undertaken with interpreting services to ensure the language needs of all individuals are met.

The response we received from the service was that various audits and actions were taken to address the recommendations. We were pleased to note on the day of this visit that the matters raised in our previous visit had been addressed and resolved.

This was an unannounced visit and we planned to meet with individuals and speak with their relatives if possible. We wanted to check if any individuals found themselves in IPCU longer than six months. We also wanted to hear from staff about the care and treatment they were delivering to patients. We were also keen to hear how staff ensured that care and treatment was being provided in line with mental health legislation and in a rights-based model.

Who we met with

We met with six individuals and reviewed the electronic care records of these individuals. We were unable to meet with any carers or relatives.

We met with one of the operational nurse managers, two of the charge nurses, the therapeutic activity nurse and a number of nursing staff.

Commission visitors

Justin McNicholl, social work officer

Mary Leroy, nursing officer

Laura Young, nursing officer

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included contact with staff, participation in their care and treatment, activities available to them, their views on how their individual needs were being met, support with their cultural and spiritual needs and their views about the environment.

We heard a variety of views from the individuals we met with regarding their care and treatment. A number of these individuals were acutely unwell. Of the positive comments we received, these were about the support individuals were receiving from staff. These included, “the staff are nice people”, “approachable”, “I see my doctor once a week and she is clear with me on what is happening next”, “they make it tolerable” and “my nurse is good, we have good chats”.

We heard several comments regarding staff which included, “they say things I don’t understand”, “my doctor does not listen”, “I’m not impressed with my doctor”, “I am fed up here” and “the doctor can be helpful, but it varies”.

We received several positive comments regarding input to the ward from the occupational therapy (OT) staff and the therapeutic activity nurse (TAN). These included, “I’ve been doing cookies once a week with the OT, I enjoy it”, “there is ping pong, very fun” and “the OT has been working with me in preparing for getting out; it’s been very helpful.” Most people that we spoke with were confined to the ward and acknowledged that on occasion they were “bored” or “fed up” but did not relate this to the lack of activities available.

The most consistent issue raised by all individuals was the low temperatures in the bedrooms of the ward. The individuals that we met with spoke at length regarding the lack of heating in their bedrooms. Individuals stated, “it is too cold”, “it is freezing in my bedroom”, “it is so cold I have to wear clothes to bed” and “they give you an extra duvet, but it is still so cold”. We discussed this with staff who advised that they were as frustrated about the lack of heating in the bedrooms as the individuals in the ward.

We were advised that the boilers in the ward had broken down several times over the last 10 years. They advised that a replacement boiler had been identified by the facilities staff of the hospital over the last number of years. Senior managers

advised that the facilities staff have been unable to obtain any approved funding for a replacement boiler.

The nursing staff spoke of strategies that they had used to address the inclement temperatures. This included leaving the bedroom doors open to allow the heat from the corridors to pass into the bedrooms in attempt to raise the room temperatures. Staff acknowledged that this was not always successful. Staff spoke of how it was positive that senior managers of the hospital had agreed to close three bedrooms to protect patients from the low temperatures in the affected bedrooms.

Individuals spoke of having no issues in having direct contact with their family or friends unless they were subject to specified person restrictions. People advised that all reasonable communication methods were open to them while they were on the ward.

We heard from nursing staff that there remains a high ratio of staff to individuals. We were informed that the ward continues to use bank staff, as well as healthcare assistants to ensure that there is adequate cover for individual needs. We noted the increased levels of acuity in the ward since our last visit. Staff reported no significant issues with nursing vacancies in the ward.

All the staff members we spoke with knew the individuals on the ward well. They were able to comment on any risks, restrictions and management plans that were in place to support individuals. The care we observed being delivered on the day of our visit appeared to be focused on de-escalation, the use of the least restrictive option and focussed on the individual's care plan goals.

We were pleased to hear that delayed discharges did not have an impact on any person's progress towards recovery. We were also pleased to note that there was no evidence of smoking occurring in the garden of the ward during this visit. Many of the staff commented on the positive and proactive impact that the new senior charge nurse and charge nurses were having on the ward. This included improvements with consistent supervision, care plan audits and improvements in patient flow.

Similar to our last visit, we met with a few individuals who were subject to the Criminal Procedure (Scotland) Act, 1995 (the Criminal Procedure Act). We heard about their frustrations as being a restricted patient in the hospital and the unpredictability of when they would be discharged. One individual raised issues regarding access to their welfare benefit payments due to their status. We followed this up with the service who were able to find a solution to the barrier that the individual faced.

Care, treatment, support, and participation

Care records

Information on care and treatment was held on the electronic record system, EMIS and the electronic medication management system used by NHS Greater Glasgow and Clyde (NHS GGC). The EMIS system record for each person contained their detention paperwork, care plans, risk assessments, physical health monitoring, admission paperwork, contact details and information on their GP.

We found the majority of records on the electronic and the paper systems to be up to date. The information was easily accessible and provided a holistic picture of individual care needs and progress.

Care plans

Care plans are a tool that identify detailed plans of the interventions that are to be delivered and effective care plans can ensure consistency and continuity of care and treatment. Care plans should be regularly reviewed to provide a record of progress being made.

During this visit we found significant improvements in the latest recording of care plans that had been introduced in 2024. We found these to be detailed, with clear evidence of them being person-centred, reviewed regularly and linked to MDT meetings. We found a focus on recovery with specific individualised goals.

Very few individuals we met with had a detailed understanding of their care goals. Most did report regular one-to-one time with nursing staff but not with their psychiatrist. Where individuals disagreed with their care and treatment, their views were recorded.

All care plans were accessible on the electronic recording system, EMIS. We advised that patient involvement and awareness of their care plans should be a consideration for the clinical team. We look forward to seeing how this has progressed when we next visit.

Risk assessments

Due to the level of risk and how unwell people can be in the ward, they require updated risk assessments to be completed and reviewed timeously. The service has adopted the Clinical Risk Assessment Framework in Teams (CRAFT). This summarises the key themes relating to the individual, including a review of the observation status.

Effective risk management in an IPCU is essential due to the level of restrictions faced by those individuals admitted there. The CRAFT documents that we reviewed lacked clear formulation and consistency. The Commission visitors found the risk

assessments were not meaningful for the individuals and failed to identify how risks were clearly managed.

Some individual observation levels were noted to be incorrect. We discussed this with the staff on the day who had a clear understanding of risk assessment and management plans, but this was not reflected in the records. The staff confirmed that significant work had taken place to update the care plans but this had not happened with the risk assessment documentation.

Recommendation 1:
Managers should ensure that risk assessments are completed which are meaningful, provide clear formulation and risk management planning.

We look forward to seeing how recording in this area has been improved during our next visit.

Multidisciplinary team (MDT)

The IPCU had a limited multidisciplinary team, with nursing staff, the pharmacist, and the ward psychiatrist. The MDT meeting was held at least once a week in the ward.

Occupational therapy, physiotherapy, psychology and other disciplines would attend if applicable or provide written reports to the chair of the meeting. Referrals could be made by the MDT to all other services as and when required.

Individuals attended the MDT meeting at least once per week and used these meetings to obtain an update on their progress, changes to their care or treatment and where they could ask questions about their progress towards discharge. It was good to see that relatives were invited to attend MDT meetings where they had the opportunity to ask questions of any staff caring for their relative.

We reviewed the MDT notes on EMIS and found these to be concise, with a narrative in place to cover the main discussions and associated actions. We did note for one individual, who was a restricted patient, there was no plan of action set out based on the outcome of their court proceedings. We felt this could have been addressed in the MDT notes. Despite this, we heard from the individual and staff that future planning and the required links had been made with the community team to prepare for the person's discharge.

Use of mental health and incapacity legislation

On the day of our visit, all nine of the individuals in the IPCU were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 ('the Mental Health Act') or the Criminal Procedure Act.

The majority of the orders in place were under the Mental Health Act. Compared to our last visit, we found that all relevant mental health paperwork including completed

social circumstances reports (SCR's) by mental health officers (MHO's) had been uploaded to the EMIS system.

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. We examined the hospital electronic prescribing and medicines administration (HePMA) system that was in place across NHS GGC to assist nursing staff with the administration of all medication. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the prescribed medication.

Where individuals have granted a power of attorney (POA) or where there has been a guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), a copy of the powers granted should be held in the care records, and the proxy decision maker consulted. Compared to our last visit, there was only one individual who was subject to a welfare guardianship order. We did not find a copy of the order on EMIS and staff agreed to address with the guardian.

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 found evidence of where there was a named person, which was recorded on EMIS and ward staff had liaised with those individuals. There was evidence that the option of having a named person was revisited by the nursing staff.

Rights and restrictions

Portree is a locked ward and has a 'locked door policy' which is proportionate with the level of risk being managed in an intensive care setting. All the people that we spoke to were clear on how they could access legal advice, or make an appeal against their legal status and how to access the local advocacy service. Individuals spoke of having met with the visiting advocacy staff and were clear on how to utilise their rights.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are subject to detention in hospital. Where an individual is a specified person in relation to these sections of the Mental Health Act and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised, and that the need for specific restrictions is regularly reviewed.

On the day of our visit, there were four individuals who were subject to these procedures, and we were told that these arrangements were reviewed regularly to determine whether the restrictions in place were still required. We noted during the visit that the level of restrictions appeared appropriate to what we found on the day.

We noted that during the visit, no individuals were subject to continuous observations and we observed staff regularly monitoring individuals' presenting symptoms.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they do or do not want. Health boards have a responsibility for promoting advance statements. On the day of the visit, we found that where advance statements had or had not been made, this was noted in the individual's record.

We visited the de-escalation room in ward. This is a room which has been designed to provide a low sensory environment for people who require a period of time away from the ward. We were told the de-escalation room had been updated with a new reinforced door and flooring installed. We heard that people would voluntarily use the room as a means to cope with their levels of stress or distress. We did not consider the room to be a therapeutic space. The room was limited in decor with rubber matting on the floor. The furniture was designed to aid with any risks to both individuals and staff. The walls in the room remain bland, with no warmth added to the decor.

Recommendation 2:

Managers should seek to ensure that the de-escalation room is improved to be a more therapeutic space for individuals.

Activity and occupation

Activity and meaningful occupation, particularly in an IPCU, is important due to the level of restrictions individuals face. People that we met that were confined to the ward and the activities they had access included ping pong, the ward gym, television, newspaper groups and the opportunity to listen to music. We observed activities undertaken by health care support workers and the appointed therapeutic activity nurse (TAN).

We met with the TAN who advised that their service had been relocated from their office in McKinnon House and they were now based on the ward. The TAN team is made up of three full time trained nurses and five healthcare support workers who work across the hospital site. The TAN input to the ward was between 10am-8pm during weekdays and weekends.

This input aims to provide support that is led by individuals' interests, which can vary from bingo, arts and crafts to music. We were informed that volunteers visit the ward each week to provide arts and crafts to people, as well as play table tennis.

We noted that there is protected time for TAN input to the ward which was essential in providing stimulation and meaningful activities. We found evidence of good working relations between the TAN and the staff group, which ensured that there was a focus on helping to reduce distress and focus on recovery.

The physical environment

The ward consists of 12 single en-suite bedrooms. There are three seating areas, a dining room, a de-escalation room, an activity room, a family room and a gym. The ward decor was reasonably well-maintained. Staff advised that a painter was due to be employed for the hospital which would ensure that paint work would be maintained on a regular basis.

We received extensive concerning comments about the temperature in the remaining nine bedrooms. Staff advised us that the concerns regarding the boiler breaking down has been ongoing since 2016. We discovered similar concerns when we visited in 2022, and we reported on these matters which resulted in the heating being fixed.

The temperatures since the boiler had broken down were reported by staff to range from 9 degrees to 14 degrees depending on the temperature outside of the building. People spoke of finding their bedrooms to be cold at night when they were required to sleep in them. We visited the bedrooms as part of the walk around the ward. We found them to be cold and uncomfortable.

We raised the lack of heating in the remaining bedrooms with the managers on the day of the visit. They spoke of various steps and strategies that were planned to address the issue including the potential installing of temporary heat panels due to one of the boilers remained out of commission. Following the visit, we raised these concerns issues regarding the lack of suitable heating in the ward with Healthcare Improvement Scotland (HIS) and the Mental Health Directorate at the Scottish Government. We remain in contact with the senior managers for an update on how this matter is being addressed as an urgent priority.

Recommendation 3:
Managers must take urgent steps to address the lack of heating to the bedrooms of the ward. Repairs must be undertaken to ensure that sustainable improvements are made to avoid a repeat of these poor conditions.

We heard from people about the washing machine and the tumble dryer in the ward not working on a regular basis. We heard, “the tumble dryer regularly stops as the filter gets blocked…it can take ages to get your clothes dry; it is really annoying having to go back and forth” and “there is only one washing machine for all the patients which seems short sighted”.

We received some comments that people would like increased portion sizes for their lunch and dinner, which we passed on to managers on the day of the visit.

We were advised of one bedroom in the ward were the sealant around the shower had mould on it. We raised these issues with managers on the day, who advised of their plans to address these individual issues with the estates department.

We visited the garden of the ward where we noted a large section which had several clumps of tall grass uncut. It was reported by staff that this part of the garden routinely struggled to drain water during the winter which meant that it was unusable by people in the ward. Staff advised that funding had been secured to improve a separate part of the garden via the volunteer service. We look forward to seeing how the improvement work will make the garden more accessible and comfortable for people.

Summary of recommendations

Recommendation 1:
Managers should ensure that risk assessments are completed which are meaningful, provide clear formulation and risk management planning.

Recommendation 2:
Managers should seek to ensure that the de-escalation room is improved to be a more therapeutic space for individuals.

Recommendation 3:
Managers must take urgent steps to address the lack of heating to the bedrooms of the ward. Repairs must be undertaken to ensure that sustainable improvements are made to avoid a repeat of these poor conditions.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk