Mental Welfare Commission for Scotland

Report on announced visit to:
Stobhill Hospital, Jura Ward, Balornock Rd, Glasgow, G21 3UW

Date of visit: 18 August 2026

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

Jura Ward is a 20-bedded unit that provides assessment and care for older adults with dementia. Jura Ward covers the catchment areas of the northeast of Glasgow and the northeast section of East Dunbartonshire local authority.

On the day of our visit, there were 19 people on Jura Ward, 16 who were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

We last visited this service in October 2024 on an announced visit and made recommendations on care planning and the ensuite doors. The response we received from the service was that care planning would be addressed with the support of the practice nurse lead and that doors with heavier magnets would be trialled, however in the meantime, magnetic saloon doors would continue to be used.

On the day of this visit, we wanted to follow up on the previous recommendations, look at compliance with part 16 of the Mental Health Act and communication with carers and proxy decision makers.

Who we met with

We reviewed the care records of seven people, all of whom we met with in person. We also met with nine relatives.

We spoke with the service manager, the senior charge nurse (SCN), the charge nurse, the lead nurse, the therapeutic activity nurse (TAN) and both consultant psychiatrists.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

What people told us and what we found

All the relatives who spoke with us were very positive in their views of the care on the ward. We were told by everyone we spoke to that they feel welcome on the ward and able to raise anything with staff.

We heard that the consultants and nursing staff were very proactive in communicating with the relatives and that they felt fully informed and were consulted regarding any care decisions, “they contact me if there is anything I need to know, even small things. I can relax and not worry knowing that”; “the consultant called us not long after the admission to discuss what would happen and to ask for our views. That hasn’t happened anywhere else”; “staff are amazing - so friendly and approachable and they actually listen and act on what you tell them”; “we get a regular update from named nurse and the consultant has called us several times to discuss things”.

The SCN and service manager told us that an improvement plan was in place to address care planning and other issues. We were advised that the ward’s first carers support group meeting was scheduled for the coming weekend, with a plan to make this a monthly event.

Care, treatment, support, and participation

Care records

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

Multidisciplinary team (MDT) reviews, care plans and their reviews, the CRAFT risk assessments and chronological notes are held on EMIS, along with Mental Health Act paperwork.

Adults with Incapacity (Scotland) Act, 2000 (AWI Act) paperwork, including section 47s and copies of Power of Attorney (POA), AWI Act guardianship orders, and do not attempt cardiopulmonary resuscitation (DNACPR) forms were held in the paper file and scanned onto the electronic record.

Care plans and risk assessments were detailed and we found completed and informative ‘getting to know me’ (GTKM), documents completed for everyone whose care we reviewed. The GTKM provides comprehensive information on an individual’s needs, likes and dislikes, personal preferences and background to enable staff to understand what is important to the individual.

All this information was reflected in the person-centred care plans. Care plans were reviewed on a regular basis and there were meaningful, detailed reviews which

charted progress, or otherwise, and provided further information on the individual's changing care needs and how their care was being adapted to meet these.

There was evidence of individual and carer involvement in the care planning process, both initially at the point of admission and during reviews of care, however care plans were not always updated to reflect the changes in care that had been delivered and that was being implemented.

Recommendation 1:
Managers should audit care plans to ensure that they are being updated to reflect changes in care needs and delivery being identified in reviews.

Where individuals suffered from stress or distress there were detailed and informative Newcastle-type formulations in place. This framework and process was developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge. The formulations provided information on potential triggers and management strategies for the individual. We found that this information was being used to deliver truly person-centred care.

Chronological notes were relevant and detailed, providing information on the individuals' presentation and how they were during the day. One-to-one sessions were recorded and we also found there were recorded one-to-one sessions with relatives, where staff were able to provide support and gather more information to aid with the care they were delivering.

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)
The ward has input from two consultant psychiatrists as well as regular input from occupational therapy (OT), psychology, physiotherapy and pharmacy; all attend the multidisciplinary team (MDT) meetings. We heard that social work referrals are made early in the admission process, however there can be delays in the allocation of social workers by Glasgow City due to workload pressures.

Input from other professionals, including speech and language therapy and dietetics, are arranged on a referral basis.

Relatives are invited to attend MDT reviews, and where they are unable to do so, the consultants and nursing staff proactively contact them to ensure they are fully involved in and kept informed of decisions.

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

MDT review notes were clear and concise; they included a summary of the individual's progress, the carers and the professionals' views. Decisions were noted and any actions required were attributed to a staff member to ensure they were followed through.

Use of mental health and incapacity legislation

On the day of the visit, 16 people were detained under the Mental Health Act.

All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment, were in place 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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required.

In relation to the AWI Act, where the individual had granted a POA or was subject to guardianship, we found information relating to this, which provided contact details for the proxy decision maker. Copies of the powers were available in all of the files we reviewed and there was evidence throughout the chronological notes and care plans of consultation with the proxy decision maker in relation to care and treatment.

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 found completed forms in all the files we reviewed.

For those who had covert medication in place, all appropriate documentation was in order.

We found completed DNACPR forms for several of the people whose care we reviewed. Where there was a DNACPR in place, consultation with families or proxies had been documented.

Anyone who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. None of the individuals whose care we reviewed had appointed a named person.

Rights and restrictions

Jura Ward continues to operate restricted entry, commensurate with the level of risk identified in the patient group. There was information on how to enter and exit the ward available near the door.

We were told that the ward has open visiting, however a poster on the entry door set out specific visiting times. The SCN told us that they encourage visitors to avoid visiting over mealtimes but are flexible and do facilitate person-centred visiting. We saw staff welcoming visitors to the ward throughout our visit and the visitors we spoke with told us they were able to visit at any time and could stay as long as they wished.

We saw posters advertising the local advocacy service and were told they were responsive to requests for input.

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. There were no individuals in the ward who were specified persons.

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 statements in the records that we reviewed.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

The ward benefits from a TAN, who provides a varied programme of individual and group activities on the ward and supports individuals to attend therapeutic groups in McKinnon House, where appropriate.

Activities offered include chair exercises, chair yoga, and chair-based games, Tai Chi for dementia and dance, relaxation, reminiscence and musical activities; playlist for life training had been booked and this will be reintroduced to the ward. There were frequent games groups including dominoes, Bingo, Connect 4, and other board games and jigsaws. Colouring books and arts and craft materials were also provided.

The ward had regular visits from therapet and from Music in Hospitals.

There were good links with the local community and, as well as going for walks in the local park, there are weekly visits to a musical memories group in the local

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

community. The local church also invites the ward to themed events, such as Halloween, Easter etc. in the church hall. There were monthly visits to Glasgow Film Theatre (GFT) for dementia friendly screenings.

Other recent outings included visits to the transport museum, outings on a boat on Loch Lomond, canal boat outings, lunch in a local hotel, and outings on the Bo'ness steam train.

Activities were tailored to the individuals' preferences and abilities, and we found activity preferences, participation and outcomes recorded in the chronological notes.

It is evident from care plans and from observing the ward that several individuals with more advanced cognitive impairment were limited in their ability to participate in activities. Staff advised us these individuals would benefit from access to sensory equipment such as twiddle muffs, a sensory table etc.

Recommendation 2:
Managers should consider allocating funds for the purchase of sensory equipment for the ward.

The physical environment

The ward is bright and spacious. The atmosphere in the ward was warm and welcoming.

There were several quiet spaces as well as the large sitting areas. Pictures of local Glasgow scenes around the ward added interest to the environment, as did the memory walls which contained a variety of old artifacts that could be used to stimulate discussion and reminiscence. We particularly liked the summer holiday themed wall.

There were well-designed, secure gardens with plenty of seating.

On our previous visits, we recommended that the use of magnetic anti-ligature saloon type doors for ensuite bathrooms should be reviewed because they dislodged easily, thus compromising individuals' dignity, and posing a falls risk should someone try to lean on them for support or to steady themselves. We wrote to senior managers, raising our concerns. They advised that doors with stronger magnets were being considered as an appropriate replacement although these would continue to be a ligature risk.

During this visit, we heard from staff that the doors can still easily be dislodged. We saw in one care plan that this was a cause of distress to the individual; this had left them feeling vulnerable and their dignity compromised.

Recommendation 3:
Managers should undertake a full reassessment of risk in the wards for older adults with dementia, considering the risk posed by the current anti-ligature doors for this specific patient group.

Any other comments

Throughout the visit we were impressed by the calm, friendly and welcoming atmosphere in the ward. Everyone who entered was greeted by staff, who introduced themselves. And we noted staff ensuring that all visitors were given the opportunity to speak to staff before leaving the ward. Staff were constantly visible in the ward engaging with individuals, chatting and participating in activities.

Summary of recommendations

Recommendation 1:
Managers should audit care plans to ensure that they are being updated to reflect changes in care needs and delivery being identified in reviews.

Recommendation 2:
Managers should consider allocating funds for the purchase of sensory equipment for the ward

Recommendation 3:
Managers should undertake a full reassessment of risk in the wards for older adults with dementia, considering the risk posed by the current anti-ligature doors for this specific patient group.

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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