Mental Welfare Commission for Scotland

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

Date of visit: 10 September 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

Nairn Ward is a 21-bedded unit in Stobhill Hospital that provides acute mental health admission.

Nairn Ward is managed offsite by Dykebar Hospital, covering the Renfrewshire area.

The service is usually located in Ward 3b, Leverndale Hospital but has been temporarily moved to Nairn Ward, to allow necessary health and safety work to be carried out. The service is expected to return to Leverndale Hospital later this year.

The ward would usually have responsibility for the Esteem Service, a mental health service for individuals aged 16 to 35 who are experiencing a first episode of psychosis. However, responsibility for the Esteem service has temporarily transferred to South Ward to support the decant of the overall service to Nairn Ward.

On the day of our visit, there were 20 people on the ward and one vacant bed.

We last visited this service in October 2024 on an announced visit and made recommendations regarding the recording of person-centred care plans and multidisciplinary team (MDT) meetings, and to ensure that individuals admitted to the service informally were aware of their rights. We also made a recommendation relating to compliance with legislation requiring hospitals to be smoke-free. In its response, the service advised that care records are regularly audited, individuals are provided with information about their rights, and information and support are available regarding smoke-free hospital policies. During this visit, we wanted to follow up on the progress made in relation to these recommendations.

Since our last visit, the Commission has also been advised of incidents that were the subject of multi-agency investigations and wider organisational learning. For this visit, we reviewed the actions taken by the service in response to issues identified through these investigations. This included consideration of the implementation of policies and procedures relating to risk documentation, physical healthcare, and communication with families and unpaid carers.

Who we met with

We met with and reviewed the care of six people, and we also reviewed the care notes of a further three people. We did not meet or speak with any relatives on the day of our visit.

We spoke with the senior charge nurse (SCN) and the lead nurse support.

Commission visitors

Gemma Maguire, social work officer
Kathleen Liddlell, social work officer
Mary Hattie, nursing officer

What people told us and what we found

Individuals we met with on Nairn Ward spoke very positively about the care and support they received from staff. Individuals told us that staff were “wonderful” and had “saved my life”. We heard that, even when staff were busy, they “always make time for me”. Some individuals also described their consultant psychiatrist as “caring”.

We found several examples of person-centred and trauma-informed approaches being used to support individuals' recovery.

There was dedicated support with the use of therapeutic interventions for individuals who experienced trauma and staff who worked sensitively, demonstrating a person-centred approach that took account of a person’s past experiences and individual needs.

The Commission was keen to speak with families and unpaid carers during the visit, however there were no family members or unpaid carers available or who wished to speak with us on the day of our visit to Nairn Ward. We were pleased to hear from individuals that they felt their families were involved in decisions about their care and treatment. One person shared with us that a family member had told them that they felt the care in Nairn Ward was "the best care" they had ever received.

Our review of care records also found that the views of families and unpaid carers were regularly sought and consistently documented, demonstrating an ongoing commitment to involving those who are important to the individual's care and recovery.

We were pleased to find improvements in the documentation of the care records, in the recording of person-centred care plans and MDT meetings. There was a dedicated legal section in individual care plans, which clearly outlined any statutory measures to which the individual was subject, including the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act), the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), and Adult Support and Protection (Scotland) Act, 2007.

This section also contained information about individuals who were receiving care on an informal basis and who were agreeing to remain in hospital voluntarily. The records demonstrated that consideration had been given to individuals' consent to admission and treatment, and where appropriate, the need for statutory safeguards was reviewed and documented.

Several of the people we met with were accessing advocacy services or seeking legal advice. We heard how Renfrewshire Council will be commissioning a new

advocacy service, the Advocacy Project. In the meantime, You First advocacy services were continuing to provide a service to individuals on Nairn Ward.

During our last visit to the service, we were impressed by the planning undertaken to prepare individuals, their families, and staff for the transition to Nairn Ward.

Although the ward is located some distance from the Renfrewshire catchment area, and public transport links can be challenging, often requiring travel through or around Glasgow city centre, the service has provided a dedicated bus service operating between Stobhill Hospital and the area surrounding Leverndale Hospital. This service transports individuals, family members, and advocacy services.

The transport provision had helped individuals maintain links with their local communities and supported ongoing contact with family and friends, which was an important aspect of an individual's recovery. During this visit, we heard that the service currently in Nairn Ward is due to return to Leverndale Hospital in the coming months, following completion of health and safety works in Ward 3B.

Care, treatment, support, and participation

Care records

We reviewed several care plans that identified key themes relating to individuals' physical health, mental health, psychological and social needs, discharge planning, and legal status. The detail recorded in care plans had improved since our last visit, and we were pleased to find that individuals were consistently consulted about their care. We found good examples of person-centred approaches, including the use of individuals' own words and views in the care planning documentation.

Care plans were regularly reviewed, with individuals' progress in recovery considered on an ongoing basis. Reviews reflected discussions and actions arising from care meetings, including one-to-one sessions with individuals, weekly MDT meetings and discharge planning meetings.

Care plans were recorded using a standard Word template, with care plan themes and interventions detailed at the beginning of the document and review entries recorded underneath. We found that information contained in the care plan themes and interventions section was not always updated to reflect information documented in subsequent reviews. An example of this was where we found recent reviews that recorded an individual was subject to the Mental Health Act and continuous intervention; this information had not been updated in the main care plan section. As a result, it took a review of multiple pages of entries to locate the most up-to-date information.

We also found that individuals' physical health needs were not consistently addressed in care plans or risk documentation. We found in one of the care records

that we reviewed, where there were diagnosed medical conditions such as epilepsy, important information about the management of these conditions was absent from the care plans and risk documentation.

During the visit, we observed staff engaging in meaningful and person-centred discussions with the Safe Care Team, who were supporting those who experienced prolonged periods of continuous intervention and, at times, who required physical restraint to maintain their own safety and the safety of others. In these situations, the care plan contained information relating to the use of continuous intervention to manage distress and risk of harm. When we reviewed the care plan, we did not find the level of detail we would have expected regarding the use of restraint or the individualised interventions that should be used to support an individual during episodes of continuous intervention and/or restraint. It was clear from our discussions with staff that a range of personalised approaches were being used to support the individual's distress, de-escalate situations, and provide support following incidents, however these interventions were not sufficiently reflected in the care planning documentation.

Recommendation 1:
Managers should ensure person-centred care plans and risk documentation clearly record individuals' physical health needs and how these will be managed and reviewed.

Recommendation 2:
The service should ensure that care plans for individuals subject to continuous intervention and/or restraint clearly document personalised de-escalation strategies, support during interventions, and post-incident care.

Recommendation 3:
Managers should ensure that care planning documentation supports clear, person-centred recording and enables staff to record, readily access and review individuals' needs, goals, views, and progress.

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.

NHS Greater Glasgow and Clyde (NHS GGC) use the Clinical Risk Assessment Framework for Teams (CRAFT) to record, assess, and manage individual risk. The Commission has previously made recommendations relating to risk documentation, particularly risk management information, following several visits to NHS GGC mental health services. We have raised concerns through our investigative work

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

following significant incidents where risk documentation and/or risk management information was missing. We have also shared this information with Healthcare Improvement Scotland to inform their inspection duties in relation to NHS GGC mental health inpatient services.

In response, NHS GGC has advised the Commission that the CRAFT policy, training materials, and associated guidance have been updated. These updates include clearer information on when risk assessments should be completed or reviewed and emphasise the importance of maintaining up-to-date risk management plans. We have also been advised that regular audit processes are in place to identify issues and support practice development.

During our visit to Nairn Ward, CRAFT documentation was present in all of the care records we reviewed. Similar to the concerns outlined in relation to person-centred care planning, we heard from staff during this visit that the CRAFT document can be lengthy and difficult to use. We also found that risk recording focused on dates and descriptions of historical incidents. While this provided a useful context and a chronology of risk events, it was not always easy to identify an individual's current risks and the actions required to manage those risks effectively.

In the risk documents we reviewed we found a few which contained individualised risk management information linked to identified risks, however in other records, important information was missing. These included details relating to physical health risks and, in some cases, clear information about how identified risks should be managed.

Recommendation 4:
Managers should ensure that risk documentation provides a clear and accurate record of current risks, and the measures in place to manage them.

Recommendation 5:
Managers and Practice Development Leads should review the current CRAFT documentation to ensure it supports staff to effectively assess, record, and manage current risks, and promotes consistent risk assessment and risk management practice.

Multidisciplinary team (MDT)
MDT meetings are held weekly on Nairn Ward and include the two consultant psychiatrists who also oversee the care and treatment of individuals admitted via ESTEEM. The MDT also includes representation from pharmacy, occupational therapy, and psychology.

When reviewing care records, we found that psychology input was not as consistently recorded as we had noted during previous visits. We discussed this with the SCN on the day of our visit and were informed that there had been a psychology

vacancy in the service for some time; we were advised that this post has now been successfully recruited to. We look forward to seeing progress in relation to psychology provision on our next visit to Nairn Ward.

MDT meetings were held weekly and records documented attendance, a summary of discussions, and actions agreed. We found that the level of detail was not always consistent. In particular, records did not consistently document the rationale for decisions, identify who was responsible for agreed actions, or specify timescales for completion.

We discussed these findings with the service on the day of our visit. The service advised that it would incorporate this feedback into its ongoing care record audit process, which includes a review of MDT meeting documentation. The Commission will consider progress in relation to this area during our next visit.

Use of mental health and incapacity legislation

On the day of the visit, 13 people in Nairn Ward were detained under 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 provided to individuals who are detained and are either capable or incapable of consenting to specific treatments. We found that consent to treatment certificates (T2) were appropriately in place and corresponded with the medication prescribed.

We identified two errors on Nairn Ward relating to certificates authorising treatment (T3). One error related to prescribed medication that was not included on an individual's T3 certificate. A second error involved an individual whose T3 certificate had expired.

We noted that the expired certificate had been identified through a nursing audit and shared with the relevant consultant psychiatrist. However, the appropriate request to rectify the issue was not made by the consultant psychiatrist until 12 days after the certificate had expired.

We followed these matters up with the consultant psychiatrist and the SCN. We advised the service to ensure that internal escalation processes for patient care incidents are followed and that incidents are investigated by managers to identify any practice issues, support learning, and reduce the risk of similar errors occurring in the future.

We identified one individual in Nairn Ward who had been prescribed intramuscular (IM) medication on an ‘as required’ basis despite not being subject to the Mental Health Act. The Commission has concerns about the prescribing of IM medication in

these circumstances, as there is no legal authority to administer it without valid consent. Any advance agreement to receive IM medication would become invalid if the individual withdrew consent at the time of administration or if restraint was required. Where an unforeseen situation arises in which IM medication may be required, the Commission's view is that services should have protocols in place to ensure that consideration is given to detention under the Mental Health Act and that appropriate legal safeguards are applied.

We discussed this issue with the SCN, who agreed to contact the consultant psychiatrist to ensure that the prescription was reviewed and removed.

Recommendation 6:
Nursing and medical staff should ensure that all prescribed medication is appropriately authorised under the Mental Health Act and that audits of treatment authorisation certificates are sufficiently robust to identify discrepancies promptly. Any errors should be escalated and investigated in accordance with local procedures to support learning and prevent recurrence.

Recommendation 7:
Managers should ensure there are clear arrangements in place to prevent the prescribing of 'as required' IM medication where there is no legal authority for its administration.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where someone had nominated a named person, we found the documentation to be accessible and the named person to be appropriately consulted.

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 identified one individual on Nairn Ward who had been assessed as lacking capacity in relation to medical treatment, however, their section 47 certificate had expired. We discussed this with the SCN on the day of our visit and advised that section 47 certificates should be considered as part of routine nursing audits. We advised that where certificates maybe required and have expired, consultant psychiatrists are notified. We also highlighted the potential benefits of using the legal safeguards section in the person-centred care plan to support this practice.

Recommendation 8:
Managers should ensure that section 47 certificates are valid and are routinely monitored through audit processes.

Rights and restrictions

During our last visit to Nairn Ward, we made recommendations regarding the consideration of rights and safeguards for individuals receiving care on an informal basis and who were agreeing to remain in hospital voluntarily.

We were pleased to find that during this visit, care records demonstrated that individuals' consent to admission and treatment had been considered and documented. Where appropriate, the potential need for statutory safeguards had also been reviewed and recorded.

Individuals we met with, and whose care records we reviewed, demonstrated an awareness of their rights in relation to consenting to care and treatment.

We also found that the views of individuals and, where appropriate, their families or unpaid carers, were consistently recorded in the care records, evidencing meaningful consultation and engagement in decisions about care and treatment.

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. We met with and reviewed the care records where individuals were subject to specified person restrictions under the Mental Health Act. We found that the appropriate documentation had been completed in relation to the restrictions applied. The records contained a reasoned opinion outlining the justification for the restrictions, and we found evidence that written information had been provided about the restrictions in place, the timescales for review, and their rights in relation to those restrictions.

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 identify any advance statements during our visit to Nairn Ward. Several of the individuals we met were not yet at a stage in their recovery where completing an advance statement would have been possible.

During discussion with the SCN, we were advised that nursing staff and advocacy services work with and support individuals to complete an advance statement whenever this is appropriate and where this is in line with the person's wishes and recovery.

Activity and occupation

We continued to find a wide range of meaningful activities and occupational therapy opportunities available on Nairn Ward.

Recovery-focused activity programmes were supported by the occupational therapy team, including occupational therapy technicians, as well as nursing staff, healthcare support workers, and psychology services. Occupational therapy services, working in collaboration with ward staff, have continued to promote engagement in activities that support recovery, wellbeing, and the development of independent living skills.

Activities available included relaxation groups, recycling initiatives, and walking groups. The occupational therapy team had also developed links with neighbouring mental health wards and secured access to kitchen facilities. This has enabled functional assessments to be undertaken with individuals to support discharge planning.

We met several individuals who were actively participating in activities and were able to describe the positive impact these had on their recovery. Some individuals gave us examples about the benefits of attending art groups and other structured activities.

When we reviewed the care records, it was not always clear what activities individuals had been offered, which activities they had chosen not to engage in, or those in which they were actively participating. As a result, the records did not consistently demonstrate how meaningful activity had helped to support the identified recovery-focused goals or how it had contributed to an individuals' progress and wellbeing.

We discussed this with the SCN and lead nurse during our visit. They advised us that our feedback would be considered during their ongoing care record audits and quality improvement activity. We look forward to reviewing progress in this area of practice during our next visit to the service.

The physical environment

Throughout our visit to Nairn Ward, we found the environment and atmosphere to be calm, welcoming, and conducive to recovery.

The ward comprises a mix of single en-suite bedrooms and shared dormitory accommodation. During previous visits to Ward 3B at Leverndale Hospital, we commented on the tired appearance of the environment and are pleased that Ward 3B has now been redecorated and updated. We look forward to visiting the service following its return to Leverndale Hospital.

Nairn Ward benefits from direct access to a spacious garden with a variety of seating areas. We noted that the outdoor environment appeared somewhat tired,

with worn tables and chairs and areas of overgrown grass. We discussed this with the SCN and lead nurse during our visit and highlighted that, should Nairn Ward continue to be used following the return of the current service to Leverndale Hospital, attention will be required to ensure the outdoor space remains welcoming and safe.

At the time of our last visit to the service, we made recommendations in relation to compliance with legislation regarding hospitals being smoke free. During this visit several individuals we met with were receiving nicotine replacement therapy which was being encouraged by staff. Despite this, we were disappointed to find that some people were smoking on the grounds with some individuals using electronic vapes openly in the bedrooms.

The Commission advises that smoking on hospital grounds is an offence, with individuals being at risk of penalty notices and fines. While we understand 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 discussed this with the SCN and lead nurse on the day of our visit and would encourage NHS GGC managers to ensure staff have clear guidance regarding the implementation of the smoking ban. The Commission continues to escalate these concerns with NHS GGC managers.

Recommendation 9 :
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

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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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