Mental Welfare Commission for Scotland

Report on unannounced visit to:
Struan Ward and Broadford Ward, MacKinnon House, Stobhill Hospital, 133 Balornock Road, Glasgow, G21 3UZ

Date of visit: 11 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

Struan Ward and Broadford Ward are acute adult admission services providing mental health care and treatment for adults aged 18 to 65 years.

Each ward has 20 beds and comprises of shared dormitory accommodation with access to bathroom facilities, as well as some single en-suite bedrooms.

On the day of our visit, there were 19 individuals in Struan Ward, with one vacant bed, and 17 individuals in Broadford Ward, with three vacant beds.

We last visited these services in 2024 as unannounced visits. At that time, we made two recommendations in relation to Struan Ward concerning legal safeguards in the administration of medication and access to outdoor space. We made four recommendations in relation to Broadford Ward concerning person-centred care planning, the use of specified person provisions under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act), the recording of multidisciplinary team (MDT) meetings, and compliance with the legal smoking ban in hospitals.

The service advised that audit processes, staff supervision and training were being strengthened to improve person-centred care planning, MDT documentation, medication authorisation, and the application of legal safeguards. We were also informed that the service would consider how outdoor space in Struan Ward could be maximised for the benefit of all individuals using the service. For this visit, we wanted to review how these actions had been implemented.

Since our last visit, the Commission has followed up incidents that were subject to multi-agency investigation and wider organisational learning. During this visit, we sought to review the actions taken by the service in response to issues identified through these investigations, including the implementation of policies and procedures relating to risk documentation, physical healthcare, and communication with families and unpaid carers.

Who we met with

Struan Ward

We met with five people during our visit. We reviewed the care notes for all of these individuals and reviewed the care records of a further two people.

Broadford Ward

We met with nine people during our visit. We reviewed the care notes for six of these individuals.

We spoke with one relative on the day of our visit.

In addition, we spoke with a range of staff across both services, including senior charge nurses (SCNs), charge nurses (CNs), a pharmacist, the therapeutic activity nurse (TAN), and the operations manager (OM) for nursing.

Commission visitors
Gemma Maguire, social work officer

Mary Leroy, nursing officer

Karen Beattie, nursing officer

Dr Sheena Jones, Consultant Psychiatrist

What people told us and what we found

All of the individuals we met with in Struan Ward spoke positively about staff. People described staff as "brand new", and said that "even when they are busy, they make time for me". Individuals also told us they valued the range and choice of activities available on the ward, and the support provided by TAN. One person explained that meditation classes had helped them feel more relaxed.

We also heard from some individuals in Broadford Ward that the compassion and understanding shown by staff had helped them feel "validated" and that their experience had been "much better" compared with how they felt they had been treated in other services. One relative we spoke with told us how the service kept them updated on their family member's progress.

Several of the individuals we met with in Broadford Ward were experiencing complex mental health difficulties, including symptoms associated with psychosis, substance misuse and, for some, concerns regarding decision-making capacity. Some of these individuals had been in hospital for a significant period.

We heard from staff on Broadford Ward that managing such complex needs could be challenging. Staff also described how the complexity of individuals' needs could create difficulties in progressing discharge plans and we heard that some were "stuck" in an admission service. Some of the individuals we met also spoke of their frustration and, at times, distress about remaining in hospital. One person told us they had been in hospital for four years and they were tearful when telling us "I just want out".

We were pleased to find that the physical health needs of the individuals we met with in Struan Ward were being appropriately monitored. We found that some individuals in Broadford Ward had medical conditions which were not addressed in the person's care plans or risk management plans.

Care, treatment, support, and participation

Care records

All care records, including care plans, MDT records and risk documentation, were accessible through the electronic recording system, EMIS.

Every care record we reviewed had a person-centred care plan, risk assessment and MDT documentation, however the quality of the information being recorded was not consistent across all of the records we reviewed in both Struan Ward and Broadford Ward.

We reviewed several care plans which identified key themes relating to individuals' physical and mental health needs, as well as discharge planning; we found the quality of recording to be inconsistent.

We were pleased to find that some care plans included the views of individuals and their families and unpaid carers. Other care plans did not record these views, despite evidence elsewhere in the clinical record that consultation was taking place regularly.

We found examples where wording and phrases had been repeated across different individuals' care plans. On one occasion, an incorrect name had been entered into an individual's care plan in Struan Ward, indicating that sections of some plans may have been copied and pasted from other records.

Although most care plans had been reviewed regularly, this was not consistent across all of the records we examined. In Broadford Ward, one individual who had been in hospital for more than three years and whose discharge was delayed, had no documented review of their care plan since February 2025.

We found evidence of nursing and medical interventions linked to the identified care plan themes, including pharmacological treatment for psychotic symptoms. There was limited detail regarding broader recovery-focused goals, such as participation in therapeutic or leisure activities, reducing social isolation, developing social skills, and progress towards discharge from hospital.

We also found that individuals' physical health needs were not consistently addressed in the care plans and the risk documentation. Two individuals in Broadford Ward had diagnosed medical conditions, but important information about how these conditions should be managed was missing from their care plans and risk documents. In Struan Ward, we found that there was little information about one individual who was experiencing pain associated with a physical health condition and what was in place to support effective pain management. We shared these concerns with the service during our visit and will continue to follow up on the individual physical healthcare issues.

The Commission has previously made recommendations regarding person-centred care planning across other NHS Greater Glasgow and Clyde (NHS GGC) mental health services. We have been advised that actions have been implemented to improve practice, including the introduction of regular audit processes, a revised person-centred care planning template, and supporting guidance.

Even though these actions have been put in place, we were concerned by the inconsistent practice we identified during this visit. We also continued to hear from staff that the documentation could be difficult to use.

The Commission also found the care planning template challenging to navigate. The template was structured as a Word document, with care themes and identified needs recorded at the beginning and review sections located separately at the end. For individuals with lengthy admissions, the document could become extensive,

requiring staff to navigate through multiple pages to locate up to date information and to record updates. The structure could make care plans more difficult to review and maintain, particularly in the context of competing clinical demands.

Recommendation 1:
Managers should ensure that care plan audits provide assurance that care planning is consistently person-centred, recovery-focused, and supports individuals' needs and outcomes.

Recommendation 2:
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.

Recommendation 3:
Managers should ensure person centred care plans and risk documentation clearly record individuals' physical health needs and how these will be managed and reviewed.

NHS GGC uses the Clinical Risk Assessment Framework for Teams (CRAFT) to record, assess, and manage individual risk. Following several visits to NHS GGC mental health services, the Commission has previously made recommendations relating to risk documentation, particularly on risk management information. We have raised concerns through our investigative work 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 that 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 Struan Ward and Broadford Ward, CRAFT documentation was present in all the care records we reviewed.

However, we were disappointed to find that information on how individuals should be supported to manage identified risks was not always clear. In some records, details of risk management strategies were limited or absent, making it difficult to determine the actions required to support individuals safely and consistently.

As we have noted with the concerns we 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 risks which were recorded 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.

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.

In comparison to Struan Ward, there were a higher number of individuals in Broadford Ward who were experiencing distress and presented with significant risks to themselves or others. The Commission understands that the unpredictable nature of acute assessment services can result in periods of increased clinical demand, however from our review of care records and discussions with staff, it appeared that challenges relating to complexity of need, delayed discharge, and substance misuse had been ongoing in Broadford Ward for some time.

We also found that care records for some individuals in Broadford Ward, did not always clearly explain why they required care in an acute assessment unit. In several cases, it was difficult to identify the recovery-focused interventions being delivered to support progress through the service, or what action had been taken to escalate concerns with the Health and Social Care Partnership (HSCP), including through delayed discharge processes or where consideration had been given to alternative inpatient services, where appropriate.

We met with one individual whose discharge had been significantly delayed due to complex mental health needs and concerns regarding decision-making capacity. Given the complexity of the circumstances, we would have expected consideration to be given to the use of a multidisciplinary decision-making framework such as the Care Programme Approach (CPA). CPA promotes collaborative working across the HSCP and is intended to support recovery-focused care, particularly for individuals with complex mental health needs; the individual was not subject to this process at the time of our visit.

We were also unable to find evidence in the care record that the delayed discharge process had been escalated applying the Scottish Government delayed discharge processes.

We discussed these issues with the SCN for Broadford Ward and the OM during our visit. We were advised that the SCN had recently assumed responsibility for the ward and welcomed our feedback. The SCN shared concerns regarding complexity of need, risk management, delayed discharge, and pressures on staff. The OM provided assurance that these issues were being considered by managers. We have continued to follow up with the service regarding each individual where concerns were identified.

Recommendation 6:
Senior managers responsible for Broadford Ward should ensure barriers to discharge are identified, escalated, and addressed promptly, with clear recovery-focused plans and appropriate care pathways in place to support individuals with complex needs.

On the day of our visit, three individuals in Broadford Ward were subject to continuous intervention (CI), an enhanced level of therapeutic care used to manage risk through continuous observation by one or more staff members. Through our review of care records and discussions with staff, we found that several individuals had been repeatedly placed on and then taken off from CI during their admission.

Staff described high levels of violence and aggression on the ward and the impact this could have on the safety and wellbeing of both individuals and staff. While we observed staff interacting with people in a compassionate and responsive manner throughout our visit, staff also told us that meeting these significant clinical demands on a sustained basis could be challenging and tiring.

Recommendation 7:
Senior managers responsible for Broadford Ward should review staffing levels and workforce capacity to ensure the safe management of clinical risks and the consistent delivery of therapeutic, recovery-focused care.

Multidisciplinary team (MDT)
MDT meetings continued to be held weekly and included nursing staff, consultant psychiatrists, junior doctors, pharmacy, occupational therapy, physiotherapy and psychology.

We were pleased to find that psychology services were supporting many individuals across the service. Individuals and staff told us they valued the input from psychology, particularly in helping people develop an understanding of trauma and mental ill health, and in providing meaningful strategies to manage distress and anxiety. We heard that psychology staff would no longer be able to attend all MDT meetings due to the need to prioritise their time and resources. However, psychology services would continue to provide feedback to MDT meetings and maintain psychology allocation meetings.

We were pleased to find that OT services have continued to support therapeutic activity as well undertaking functional assessments to help people prepare for discharge.

We met with a pharmacist during our visit and heard from multiple members of staff about the positive impact that their visibility and presence has on the wards. Staff described how helpful it was to have regular opportunities to consult with the pharmacist on individuals' medication, including the management of side effects and pain.

We heard that the pharmacist's contribution to MDT meetings has supported treatment planning for individuals' physical health needs and helped reduce polypharmacy where appropriate. We were also pleased to hear that the pharmacy service works closely with community mental health teams, GPs, and local pharmacies to support effective discharge planning and continuity of care.

The impact of substance misuse appeared to be significant for many individuals in Broadford Ward. We heard that some people were accessing illicit substances that was creating ongoing challenges in managing risks to themselves and others. We discussed this with the OM who advised that Healthcare Improvement Scotland and Police Scotland were involved in work to manage issues related to substance misuse across the Stobhill Hospital site.

We discussed the role of Alcohol and Drug Recovery Services (ADRS) during the visit. We found that referrals and involvement of ADRS appeared to occur on a case-by-case basis, with one person we met with asking us to ensure they were referred to ADRS. We discussed whether a more consistent ADRS presence in the MDT would better support engagement from the point of admission, provide information and support to individuals, and offer consultation and guidance to staff when developing care plans and risk management plans. We were advised managers were reviewing how best to optimise support from ADRS services and they would consider our feedback. We will continue to follow up with the service regarding this issue.

For individuals who were subject to CPA meetings, we found that records of CPA meetings provided detailed accounts of MDT discussions, decisions, and agreed actions. CPA meetings were not held regularly and not all individuals were subject to CPA, although we would still expect individuals' progress, recovery, and treatment plans to be reviewed and recorded through weekly MDT meetings.

In Broadford Ward, we found that actions agreed at CPA meetings were not always reflected in subsequent MDT records, making it difficult to understand how care and treatment plans were being progressed. We had previously made recommendations regarding MDT recording in Broadford Ward and were disappointed to find that

attendance, discussions, decisions, and agreed actions were still not being documented consistently in MDT records.

As a result, it was not always possible to see how decisions had been reached, whether agreed actions had been implemented, or how individuals' care, treatment, and recovery had been reviewed and progressed.

Recommendation 8:
Managers responsible for Broadford Ward should audit MDT records to ensure attendance, discussions, decisions, and agreed actions are clearly documented and recorded consistently.

In Struan Ward, MDT records clearly documented attendance and provided detailed accounts of discussions. We were also pleased to find evidence of input from community services, including social work and community mental health teams. Records that we reviewed included clearly identified actions arising from discussions, however this was not consistent across all records; some MDT entries contained no documented actions.

Use of mental health and incapacity legislation

On the day of the visit 23 people across Struan Ward and Broadford 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. The Commission has previously made recommendations in relation to appropriate authority being in place to provide treatment to individuals under the Mental Health Act. We had been advised that regular audits were being carried out in relation to prescribed medication and authority to administer treatment.

We found that consent to treatment certificates (T2) were appropriately in place and corresponded with the medication prescribed in both wards. In Struan Ward, we identified that all certificates authorising treatment (T3) were in place and corresponded with the medication prescribed.

We identified one error in Broadford Ward where prescribed medication was not included on the individuals certificate authorising treatment (T3). Although nursing staff had completed an audit of treatment authorisation certificates, the discrepancy had not been identified. We followed this up with consultant psychiatrist who subsequently took appropriate action to ensure that all medication was lawfully authorised.

Also, in Broadford Ward, we found that one individual had been prescribed three different types of ‘as required’ medication, in addition to two different intramuscular medications. It was not clear what guidance was available to nursing staff to support decision-making about which oral ‘as required’ medication should be administered in specific situations.

We discussed this with the pharmacist on the day of our visit, who agreed to raise the matter with the individual's responsible medical officer (RMO) to ensure the prescribed medication was reviewed. Following the visit, we have continued to seek clarification from the RMO regarding the protocols and guidance in place to support nursing staff when making decisions about the use of multiple prescribed ‘as required’ medications.

In general, we were pleased to find that intramuscular medications were rarely being used.

Across both wards, we found that three T3 certificates were missing from the paper documentation held in the treatment room. Although the certificates were available in the electronic care records, we were advised that nursing staff rely on the paper records in the treatment room to check that the appropriate authority is in place before administering medication.

Recommendation 9:
Nursing and medical staff should ensure that all prescribed medication is appropriately authorised under the Mental Health Act, and that regular audits of treatment authorisation certificates are sufficiently robust to identify any discrepancies.

Recommendation 10:
Managers should ensure that all current T3 certificates are available in the treatment room documentation.

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 documentation to be accessible and the named person to have been appropriately consulted.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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 met with one individual on Broadford Ward who had been assessed as lacking capacity to make welfare and financial decisions. We discussed this with staff, who expressed the view that the individual lacked capacity to make decisions about medical treatment, however there was no section 47 certificate in place authorising medical treatment.

On the day of the visit, the SCN agreed to raise this with the individual's RMO and highlight the need to consider whether a section 47 certificate was required. We will continue to follow up on this matter.

Recommendation 11:
Medical staff should ensure that, where a s47 certificate is required, it is completed for individuals in line with the code of practice for medical practitioners.

Some individuals we met with had been assessed as lacking capacity in relation to welfare or financial decision-making. The Commission advises that services should ensure the rights of individuals who lack capacity are upheld and that appropriate legal safeguards are sought without delay. This is particularly important where an individual is experiencing a delay in their discharge from hospital.

In Struan Ward, where concerns about welfare or financial decision-making capacity had been identified, care records generally contained information about relevant safeguards, including welfare guardianship arrangements and guardianship applications which were in progress. We were unable to locate welfare guardianship documentation for one individual during our review of care records, however nursing staff were able to locate the documentation and ensure it was uploaded to the individual's electronic care record.

In Broadford Ward, some individuals had either been assessed as lacking welfare or financial capacity, or concerns had been raised regarding the person’s decision-making capacity. One individual was subject to welfare guardianship; although records referred to the need for welfare powers, there was no clear confirmation in the care record that a guardianship order was in place. For other individuals, concerns regarding welfare or financial decision-making capacity had been identified, but the actions being taken to progress assessments and consider safeguards under the AWI Act were not always clear.

We found that some care records contained details about individuals' finances being managed, including under Part 4 of the AWI Act. However, information relating to the person's capacity and consent was not recorded consistently. The Commission advises that where concerns exist about an individual's ability to make welfare or financial decisions, assessments and consideration of appropriate safeguards should be progressed without delay and clearly documented in the care record. We

discussed these issues with the SCN and OM on the day of our visit and we will continue to follow up on individual matters.

The Commission has developed a range of learning resources in relation to the AWI Act, in partnership with NHS Education for Scotland. We also have produced guidance for health and social care staff on supporting individuals who lack financial decision-making capacity. The training can be accessed here: New TURAS Learn Zone – Adults with Incapacity | NHS Education for Scotland

Recommendation 12:
Managers should ensure that capacity assessments and the progression of safeguards under the AWI act are undertaken promptly and clearly documented in care records.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is made 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, one person in Broadford Ward was subject to specified person measures under the Mental Health Act.

We reviewed the care records for the individual and found that the appropriate paperwork had been completed for the individual in relation to restrictions on telephone use (RES3).

The person had not been provided with the required written information about the restrictions imposed on them, including information on review timescales and their rights. We discussed with the SCN and the OM during our visit who advised this would be escalated to the RMO for action.

Recommendation 13:
When an individual is made a specified person, managers should ensure they are provided with written information about the restrictions imposed, the timescales for review, and their rights.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to a written statement 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.

Where individuals had an advance statement in place, the electronic system provided an alert to ensure staff reviewing the persons record were aware. We found some evidence that advance statements were being discussed in MDT meetings, including

one individual who had declined support to complete an advance statement. We also recognised that many of the individuals we met with were experiencing acute symptoms associated with mental illness and may not have been able to engage in completing an advance statement at that time. In discussion with the SCN, we were advised that nursing staff and advocacy services support individuals to complete an advance statement whenever it is appropriate to do so.

Some individuals we met with had been admitted on an informal basis. We met with and reviewed the care records of several individuals who were receiving care informally; most understood their rights in relation to this. For some individuals in Broadford Ward, they told us while they had agreed to remain in hospital, there were aspects of their care and treatment with which they did not agree with. It was not clear whether they understood their right to refuse treatment, or whether capacity to consent had been fully considered. Two individuals we met on Broadford Ward had been admitted on an informal basis and requested further information about advocacy services. Advocacy staff were present on the ward at the time of our visit, and ward staff agreed to ensure these individuals were provided with information about advocacy and supported to engage with the service.

We found little evidence in the care records that consent to treatment, or information about individuals' rights as informal patients, had been discussed following the person's admission. The Commission consider that rights and consent to care and treatment should be revisited throughout an individual's inpatient stay, particularly where there are changes in circumstances, treatment, or decision-making capacity.

We discussed these issues with the SCN and the OM on the day of our visit and followed up with the consultant psychiatrist in relation to one individual.

The Commission advises that the use of rights-based care plans would help ensure that consent, legal safeguards, and individuals' rights are actively considered throughout admission, while supporting the provision of appropriate rights-based information.

Recommendation 14:
Managers should ensure that individuals are informed of their rights and that consent to treatment is clearly recorded and regularly reviewed throughout admission.

The Commission has developed *Rights in Mind.*[1] 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.

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

Activity and occupation

We were pleased to hear that a range of therapeutic and leisure activities continued to be available to individuals across the service. Activities were supported by the TAN, nursing staff, occupational therapy staff, and also included pet therapy, wellbeing groups, music, photography, and community-based trips.

We found information displayed on the wards about the activities available and heard from individuals that these opportunities were valued.

When reviewing care records, we found evidence that individuals were being offered a range of activities and that the TAN, nursing, and occupational therapy staff were making efforts to encourage participation.

We found that the purpose-built activity room in Broadford Ward appeared to be used primarily for storage and the activity planner displayed on the whiteboard was dated June 2026, suggesting that the room had seen limited recent use for planned activities.

During our visit, we observed that many individuals in Broadford Ward were pacing or waiting in the main corridor. Several people required frequent staff intervention throughout the day when they became distressed. Some individuals told us that they felt unsafe at times and commented that staff appeared very busy. Others told us that there was "not much to do" and that they felt bored.

We discussed these issues with the OM and the SCN on the day of our visit and were advised that the TAN for Broadford Ward was on long-term absence. While support was being provided by the TANs from neighbouring wards, staff reported that the availability of meaningful activities had reduced. We also heard that while nursing staff continued to make efforts to facilitate activities, the competing clinical demands, particularly on Broadford Ward, made it difficult to provide these consistently.

We were advised by the OM that support from other wards will continue be provided to Broadford Ward until the TAN returns to post.

The physical environment

On our previous visit to Struan Ward, we made a recommendation regarding maximising access to outdoor space for individuals who may be restricted to the ward environment. We were pleased to find during this visit that a seating area had been provided in the front garden and we heard no concerns about access to outdoor space from the individuals we met with during our visit.

We also found that some furnishings in Struan Ward were being replaced and that environmental improvements had been undertaken, including redecoration of the duty room.

When we last visited Broadford Ward, we found the environment to be bright and spacious. During this visit, we heard how work was ongoing to improve the outdoor space in Broadford Ward. We look forward to seeing progress with this.

The television in the main lounge was out of order and the activity room was not in use. We heard that the second lounge, which contained a television, was dark and cramped. Overall, we found there was limited therapeutic and leisure space available on the ward for individuals to engage in meaningful activities, manage distress, or access a quiet environment away from the main ward area.

We have previously made recommendations to NHS GGC services 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 using garden or the entrance areas to smoke.

The Commission advises 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 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.

Recommendation 15:
Managers should review the environment within Broadford Ward to ensure that people can access a range of calm, quiet and therapeutic spaces to support individual recovery.

Recommendation 16:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plan audits provide assurance that care planning is consistently person-centred, recovery-focused, and supports individuals' needs and outcomes.

Recommendation 2:
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.

Recommendation 3:
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 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.

Recommendation 6:
Senior managers responsible for Broadford Ward should ensure barriers to discharge are identified, escalated, and addressed promptly, with clear recovery-focused plans and appropriate care pathways in place to support individuals with complex needs

Recommendation 7:
Senior managers responsible for Broadford Ward should review staffing levels and workforce capacity to ensure the safe management of clinical risks and the consistent delivery of therapeutic, recovery-focused care.

Recommendation 8:
Managers responsible for Broadford Ward should audit MDT records to ensure attendance, discussions, decisions, and agreed actions are clearly documented and recorded consistently.

Recommendation 9:
Nursing and medical staff should ensure that all prescribed medication is appropriately authorised under the Mental Health Act, and that regular audits of treatment authorisation certificates are sufficiently robust to identify any discrepancies.

Recommendation 10:
Managers should ensure that all current T3 certificates are available in the treatment room documentation.

Recommendation 11:
Medical staff should ensure that, where a s47 certificate is required, it is completed for individuals in line with the code of practice for medical practitioners.

Recommendation 12:
Managers should ensure that capacity assessments and the progression of safeguards under the AWI act are undertaken promptly and clearly documented in care records.

Recommendation 13:
When an individual is made a specified person, managers should ensure they are provided with written information about the restrictions imposed, the timescales for review, and their rights.

Recommendation 14:
Managers should ensure that individuals are informed of their rights and that consent to treatment is clearly recorded and regularly reviewed throughout admission.

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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.

Contact details

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Mental Welfare Commission 2026