Mental Welfare Commission for Scotland

Report on announced visit to:
Ailsa Ward, Stobhill Hospital, Balornock Road, Glasgow, G21 3UW

Date of visit: 7 July 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

Ailsa Ward is a 20-bedded slow stream rehabilitation ward, for people living in the north-east area of Glasgow. On the day of our visit, there were 20 people in the ward.

Ailsa Ward provides rehabilitation assessment and treatment for people with major mental illness. At the time of our visit, there were approximately 11 rehabilitation patients in the ward. We heard from senior staff that there had been 12 discharges from the ward over the preceding year. This meant that a number of people in the ward were relatively new to the service and still at an early stage in their rehabilitation journey.

Ailsa also provides hospital based continuing complex care to people who had been assessed as requiring medical treatment in hospital. There were six people who required this type of care at the time of our visit.

We were told by senior staff that the service also has a role in supporting people with complex community care and support needs through their discharge process.

We spoke with medical staff about whether there were any people in the ward who were considered to be 'delayed discharges'. This means when a person is ready to leave hospital, but the appropriate care and support had not yet been identified for them. There were no people who were considered to be a delayed discharge when we visited. Nine people had active discharge plans in progress.

We last visited this service in March 2023 on an announced basis. Following this visit we made four recommendations which included ensuring that multidisciplinary meetings meaningfully involved people, that care plans were regularly audited to ensure that people were involved in their care plan reviews and that they were person-centred, that section 47 certificates and treatment plans were completed in line with the code of practice and that the garden area was cleaned and maintained.

In response to these recommendations, we were told about a discharge readiness tool to support care planning when people were getting ready to leave hospital, about an ongoing audit of care plans, about the GP having a role in ensuring that s47 certificates and treatment plans are completed in line with guidance and about the work that had happened to clean the garden area and its use for therapeutic activities.

On the day of this visit, we wanted to meet with people, families, carers and staff, to follow up on progress on the previous recommendations, and look at ongoing care and treatment.

Who we met with

We met with and reviewed the care of eight people, seven who we met with in person and reviewed care notes for one further person. We also spoke with two relatives.

We spoke with the interim service manager, the senior charge nurse, the lead nurse and the consultant psychiatrist.

Commission visitors

Andrew Jarvie, engagement and participation officer

Sheena Jones, consultant psychiatrist

Justin McNicholl, senior manager (projects)/social work officer

What people told us and what we found

The main thing that people wanted to talk to us about was the food. We heard from people that there was a catering menu that repeated every two weeks and that the food was repetitive and boring. This was important as people could be in the ward for long periods.

People also told us that they would like to cook their own food but that they couldn't access the therapy kitchen to do this.

Some people spoke about wanting to be able to decorate and personalise their bedroom areas and have more of their own belongings in the ward. One person told us that they wanted to put things up on the walls, but this was discouraged. We were told that when people brought electronic devices into the ward that it could take weeks for them to be tested and returned to them.

Another person spoke about wanting to customise their room because it felt like "a prison cell". They also said that they felt they were "treated like a baby" because the food was being provided when they were able to cook everything themselves.

One person that we spoke to said that being in the ward had given them some peace and stability and that for the first time they could start to build their life.

In general, we heard that people had good relationships with the multidisciplinary team (MDT) and we saw positive and supportive interactions between people and nursing staff during our visit to the ward. We did hear from one person that some of the night staff were less patient than others and we shared this concern with the senior charge nurse.

One person and their family member told us that they did not know about, and had not been involved in, the MDT ward meetings. When we reviewed the person's care records, we could see that the person had only recently been admitted and there had only been one ward meeting since then, which the person had attended. We could also see that the nursing team had contacted the person's family member and had recorded that they would be invited to future meetings.

Another family member spoke about their relative having been in and out of mental health services for many years. They said that the time being taken by the ward staff to get to know their relative and to provide them with care and treatment gave them more confidence than they had ever had that their relative would have a successful move to the community.

Care, treatment, support, and participation

We reviewed peoples' care records on the electronic record management system, EMIS. We found a wide range of useful information recorded on the system and

found it easy to find the information that we were looking for. The system had useful alerts to notify staff about a person's diagnosis, any risks in relation to their care and treatment, physical health and the use of legislation.

We could see that people were meeting with nursing staff regularly and that those contacts were being recorded on the system and included information about the person's activities and their health.

We could see that the clinical risk assessment formulation toolkit (CRAFT), the standard risk assessment and management tool used in the unit, was regularly reviewed and updated at the time of the MDT ward meeting.

We found a range of assessments by various members of the MDT, including occupational therapy, evidence of referrals where appropriate to other professionals and psychological formulations to support people in their rehabilitation.

Care records

We made a recommendation about person-centred care plans at the time of our last visit, and we were keen to see progress with care plans during this visit. People's care records were held on EMIS. We were able to access a wide range of information about individuals while using this system.

We heard from the senior charge nurse that care plans were regularly reviewed by senior nursing staff and that the named nurse for each person would encourage people to take an active role in their care planning and record when the person had declined to take part.

A standard person-centred care plan (PCCP) was introduced across mental health services in Glasgow and had been in use in Ailsa Ward since March 2025. We reviewed the PCCP for eight people in Ailsa Ward.

The structure of the PCCP had sections for each of the following: physical health, mental and psychological health, substance and alcohol use, social needs, legal aspects of treatment, and spiritual needs.

At the time of our visit, we found that there was a lack of a consistent approach to the completion of the care records for people in Ailsa Ward, with different staff using the PCCP in different ways.

We did not find that views of the individual were adequately considered in the majority of the PCCPs we reviewed. We were told that people often did not want to engage in discussions about their care plans and where possible a person's wishes would be sought during conversations at other times.

The PCCPs that we reviewed focussed on the aims, actions and responsibilities of the nursing team and other professionals involved in each person's care and treatment. We did not see that the care plans included goals and outcomes that would be meaningful to the person and that could be achieved over time. We also did not find that for broader actions that were required, these were not broken down into smaller meaningful goals that could be more manageable for people to achieve.

We could see that the PCCPs were regularly reviewed but in a number of cases the reviews repeatedly stated that nothing had changed or that the person had not engaged in the review.

We could also see examples where there was new and important information recorded in the review section of the PCCP, but the main text of the care plan was not updated. This could mean that important information is not readily accessible or is missed by new staff who focus on the main sections of the care plan.

We appreciate that the nursing staff are just becoming familiar with the PCCP document but consider that the previous recommendation in relation to care plans continues to need to be addressed and have therefore repeated this recommendation. We spoke to the senior charge nurse and interim service manager about this at the time of our visit.

Recommendation 1:
Managers should regularly audit care plans to ensure reviews are taking place on a consistent basis, that they are person-centred, include all the individual's needs, ensure individuals participate in the care planning process and that they and their family and carers are given opportunities to engage in care plan reviews.

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)
We were told by senior staff that there had been recent recruitment to nursing vacancies and that there were no significant gaps in nursing staff levels. In addition to the nursing team, which was led by a senior charge nurse, supported by two charge nurses, Ailsa Ward had a therapeutic activity nurse, a part time consultant psychiatrist and a consultant psychologist.

The consultant psychologist post had been vacant due to maternity leave, but cover had been provided where needed by the psychology service. We heard that psychology input was valuable to people and staff. The psychologist provided monthly formulation meetings to support a holistic understanding of people's mental

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

health, supported reflective practice and provided cognitive remediation therapy (CRT) in conjunction with the nursing team.

We heard that occupational therapy (OT) provision to the ward had changed since our last visit. In the past there had been a ward-based part-time occupational therapist and full-time assistant. Access to OT was now on a referral basis and there were mixed views about this among the MDT. We heard that this change meant that there were fewer cooking opportunities for people in the ward. However, we also heard that the change meant that it was possible for multiple OT assessments to happen at once, which had not been possible in the past and led to delays.

The MDT could also refer to other professionals where needed and this included dietetics, speech and language therapy and physiotherapy. There was no provision for podiatry services which were organised on a private basis when required.

Ailsa Ward had a visiting GP service provided by a local medical centre three times per week and access to the psychiatric 'duty doctor' in between times. The GP undertook all annual health checks, in addition to any other physical healthcare interventions that were required, for example, monitoring of medication such as clozapine and lithium, monitoring of high dose medication and diabetic monitoring.

The ward also had support from pharmacy staff who could complete medication reviews and participated in the ward meetings.

There were weekly ward MDT meetings. The care and treatment of each person in the ward was discussed at least once every four weeks at the MDT meetings. There was the opportunity at each MDT to discuss any urgent issues that had arisen. We could see that people and their families were invited to the MDT meetings, and it was recorded whether or not people wished to attend. In some records we could see that there were additional MDT meetings involving the discharge and resettlement team (DART) when they were involved in a person's discharge planning.

There was an entry made in the EMIS care record after each MDT meeting with information about who attended the meeting, the person's mental and physical health, their recent activities, any recent concerns, legal aspects of care including whether the person had an advance statement, and risk assessment and management.

At the time of our last visit, we made the recommendation that managers should ensure that MDT meetings are goal-focussed and that the intended progress is shared with individuals. We reviewed MDT meeting minutes with this in mind and did not see that there were specific goals identified in the MDT meetings that also related to the person's person-centred care plans.

Recommendation 2:
The senior charge nurse and service manager should ensure that MDT meetings are goal focussed and relate to each individual's person-centred care plan.

In addition to the weekly MDT meetings there were also three-monthly Care Programme Approach (CPA) meetings which families, carers and social work teams attended. These were formal meetings with a clear structure to support decision making when people had complex health needs and there were multiple professionals involved. An equivalent review meeting occurred every three months for people who were not reviewed via CPA.

In addition to the MDT and DART (who linked with social work, housing and community organisations) a local mental health network regularly visited the ward to offer 'Patient Conversations' groups which people could attend if they wished.

Use of mental health and incapacity legislation

On the day of the visit, 17 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995.

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment were easily found in electronic and paper files.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

The T2 and T3 forms were kept in a paper format in a folder in the treatment room. There was also an alert in each person's electronic care record about the T2 or T3 forms, including information about when it would expire. We found that all T2 and T3 forms were completed correctly and corresponded with all the prescribed medication.

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. None of the people that we met with had a named person.

For those people that were under the AWI Act, we found the relevant documentation in the person's electronic care records.

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 reviewed section 47 certificates in peoples' files and found them to be up to date and with information about standard healthcare procedures (often referred to fundamental health care procedures). We did not find any section 47 treatment plans, even when people had complex physical and mental health treatment needs and despite us having made this recommendation before.

Recommendation 3:
Managers and medical staff should ensure that where a patient lacks capacity section 47 certificates and treatment plans are completed to authorise medical treatment.

Rights and restrictions

We heard that there was a regular advocacy drop-in group in the ward but that this was often not taken up by people. One of the charge nurses was reviewing advocacy provision in the ward to improve people's links with advocacy. We look forward to hearing more about this.

We also heard from the senior charge nurse about recent work undertaken in relation to smoking in the garden and the ward, which had been a significant issue, particularly overnight. This had been helpful in improving the ward environment for people and staff. We could see in the minutes from the community meeting that people in the ward were upset about the smoking restrictions and heard that there was still a tendency for people to smoke near the entrance to the ward, despite the hospital being a designated non-smoking site. When we spoke with the senior charge nurse and service manager it was not clear what guidance they had been given by senior managers as to how to address the issue of people smoking on site or how this was being managed elsewhere in the service.

Recommendation 4:
Senior managers should ensure that there is clear guidance for clinical staff as to their responsibilities when people are smoking on the hospital site, in line with legislation, to ensure a consistent approach and support therapeutic relationships.

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. There were no people who were subject to specified person restrictions at the time of our visit.

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 found reference to advance statement processes in the minutes of peoples' electronic care records, but we did not review any advance statements during our visit.

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

Ailsa Ward had a therapeutic activity nurse who supported people to engage in a range of activities in the ward, elsewhere in the hospital and in the community. We heard from people and from staff how much this role was valued.

An activity timetable was displayed on the wall in the activity room and included a range of activities including breakfast and soup groups, exercise and walking groups, relaxation and mindfulness, arts and crafts, and gardening and social activities. We also saw information recorded in people's electronic records about their involvement in recent outings to a heritage centre and to the seaside.

Other activities in the ward included a visiting therapy pet, use of the hospital and community gyms and leisure centres, guided art therapy groups provided by Nemo Arts, and church and spiritual outings.

The therapeutic activity nurse had also run psychological groups with support from psychology on topics such as sleep hygiene, managing emotions and a weekly talking therapy group.

There was a weekly community meeting for people in Ailsa Ward led by the therapeutic activity nurse and nursing staff. We saw information about what had been discussed at recent meetings on the noticeboard in the main entrance.

We were told by senior staff that occupational therapy provision to the ward had changed since our last visit. In the past the ward had their own dedicated occupational therapy team. Now people in Ailsa Ward have to be referred to the occupational therapy service. Whilst this has meant that a number of simultaneous assessments can happen at the same time due to the increased numbers of available therapists, we heard that this change had had a negative impact on people and in particular on their access and use of the therapy kitchen. The therapy kitchen can now only be accessed during the activity sessions (which is in general the

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

morning breakfast group and a soup group held at lunchtime once per week) or when people are having their occupational therapy assessment. We heard that people in the ward found this particularly difficult given the fortnightly menu rotation, which meant that people who could be in the ward for long periods of time were eating the same food repeatedly.

We were told that the ability to offer a wider range of meal preparation choices was limited by the need to follow local healthy eating recommendations set out by the dietetics department. Even though there was a weekly soup group in the ward, soup was already on the regular menu so having this option did not increase the choice for people and did not support the development of other cooking skills.

We asked the service manager whether people in the ward could be allocated a budget to support self-catering as an alternative to the hospital food, however, this would be difficult as people cannot access the therapy kitchen without support due to additional health and safety concerns.

Recommendation 5:
The service manager should review the use of the therapy kitchen in Ailsa Ward to ensure that people can achieve their person-centred goals and to support their progress to the community.

The physical environment

Ailsa Ward is situated at the edge of the hospital campus. It is a modern building in a quiet location with views of neighbouring countryside. We found the ward to be bright and airy and in good repair. We could see information boards in the main entrance and elsewhere in the ward which provided information about activities, mental health, advocacy, the chaplain service and the community group.

In the main entrance there is an activity room with tables and chairs for people to use for arts and crafts, a seating area and a play station console with two gaming chairs. There were a range of games, books and craft materials available.

In the centre of the ward there is a sitting room with a television and an adjacent dining room and servery with a water fountain. There is also a servery off the main corridor where people can make hot drinks and store food and drinks in the cupboard and fridge space. There is also a treatment room which is well equipped and had sufficient room in which to undertake people's observations.

There is an additional female lounge between the activity room and the main corridor and a quiet lounge at the other end of the ward for people to use and to meet with visitors.

The ward has access to a long garden area which runs along the back of the ward, and which can be freely accessed from many areas. We found the garden to be clean

and tidy with a range of garden furniture for people to sit on and a number of garden activities available for people to use, such as a large 'Connect 4' game.

There is a functional kitchen in the ward which has both gas and electric cookers in addition to a countertop grill and microwave oven.

We were told by the senior charge nurse that the laundry and one of the activity rooms remained locked due to the sink fittings in those rooms which posed a risk as potential ligature points. People were able to access the laundry with support and there were no concerns raised about this. We were told by the senior charge nurse that she was considering how to adapt the activity room so that people could use this space and we look forward to hearing progress with this.

The ward comprises of 12 single rooms and two four-bedded dormitories. There were no vacant beds on the day of our visit. The two dormitories were at opposite ends of the main corridor. Each dormitory has two toilets and two showers. The rooms were bright and clean, and the furniture was in good condition.

The 12 single rooms each had an en-suite with a shower and toilet, with built in furniture and a window. Due to previous work in relation to ligature points, the doors to the en-suite rooms have been removed and replaced with light swing doors which were attached with magnets. We heard from nursing staff that these often fall down and that doors with stronger magnets were being trialled in one of the other mental health wards. We look forward to hearing of progress with this work. It was reassuring to hear that people could lock their bedroom doors when using their en-suite and we could see that the en-suite areas were not visible from the doorway.

Where possible the bedroom areas are split so that one end of the ward was for males, and the opposite end of the ward was for females. The charge nurse told us that this was not always possible due to the gender mix in the ward, in which case a risk assessment was used to allocate bedrooms to people.

We could see that the bedroom areas were clinical and lacked a homely feel. This was particularly true of the dormitory spaces. Whilst some people had some of their own possessions in their rooms there was little in the way of decorations or soft furnishing that would make these areas feel more personal and welcoming. This issue was also raised by some of the people that we spoke with, as above.

Recommendation 6:
The senior charge nurse and service manager should review the ward environment, with people in the ward, to ensure that people can have their own possessions and contribute to the ward décor, where appropriate.

Summary of recommendations

Recommendation 1:
Managers should regularly audit care plans to ensure reviews are taking place on a consistent basis, that they are person-centred, include all the individual's needs, ensure individuals participate in the care planning process and that they and their family and carers are given opportunities to engage in care plan reviews.

Recommendation 2:
The senior charge nurse and service manager should ensure that MDT meetings are goal focussed and relate to each individual's person-centred care plan.

Recommendation 3:
Managers and medical staff should ensure that where a patient lacks capacity section 47 certificates and treatment plans are completed to authorise medical treatment.

Recommendation 4:
Senior managers should ensure that there is clear guidance for clinical staff as to their responsibilities when people are smoking on the hospital site, in line with legislation, to ensure a consistent approach and support therapeutic relationships.

Recommendation 5:
The service managers should review the use of the therapy kitchen in Ailsa Ward to ensure that people can achieve their person-centred goals and to support their progress to the community.

Recommendation 6:
The senior charge nurse and service manager should review the ward environment, with people in the ward, to ensure that people can have their own possessions and contribute to the ward décor, where appropriate.

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