Mental Welfare Commission for Scotland

Report on unannounced visit to:
Stobhill Hospital, Isla Ward, Balornock Rd, Glasgow, G21 3UW

Date of visit: 4 March 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

Isla Ward is a 24-bedded unit, providing assessment and treatment for older adults with a functional mental illness. The catchment area is for the northeast of Glasgow and the northeast section of East Dunbartonshire local authority.

On the day of our visit, there were no vacant beds. There was one patient boarding in from another health board area and eight patients boarding in from adult services, however all were age-appropriate placements. Most adult service boarding placements arise because of the health board policy on the transfer of patients from adult to older adult services, which requires a period of three months stability in the community before transferring.

We last visited this service in October 2024 on an announced visit and made recommendations on the electronic care planning system and the provision of doors for ensuite bathrooms. The response we received from the service was that the care planning issue was being addressed and a new type of anti-ligature door was to be trialled.

On the day of this visit, we wanted to follow up on the previous recommendations and look at activity provision and communication with relatives.

Who we met with

We met with, and reviewed the care of nine people, six who we met with in person and three who we reviewed the care notes of. We also met with one relative.

We spoke with the senior charge nurse, the lead nurse, the interim inpatient service manager, and members of the nursing team.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

Mark Richards, nursing officer

What people told us and what we found

The ward had a warm, welcoming and calm atmosphere. Throughout the visit we saw kind and caring interactions between staff and patients. Staff were visible and approachable and knew the people well.

The relative and the patients we spoke with were positive about communication from staff; we heard that staff are "always happy to chat" and were available to answer any questions. The people we met with told us they felt safe and cared for.

Care, treatment, support, and participation

Care records

Information on individuals' care and treatment was mostly held on the electronic record system, EMIS and the electronic medication management system, HEPMA.

Care plans, nursing assessments, multidisciplinary team (MDT) reviews and chronological notes were held on EMIS, along with paperwork relating to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Documentation for the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) was held in the paper files, although we found PoA documents and section 47 certificates that had been scanned and added onto the EMIS system.

In the care plans we reviewed, we found that these were person-centred and addressed both physical and mental health needs; we found that risk assessments were detailed and reviewed regularly. Chronological notes were relevant and meaningful.

The care plans were informed by the risk assessments and were regularly evaluated, however, we found one instance where the care plan was completed two weeks after admission despite the risk assessment having been completed and there having been multidisciplinary team (MDT) reviews of care and care decisions having been made. Staff acknowledged this was not good practice and advised us that the delay was due to the high level of clinical activity in the ward at the time.

Recommendation 1:
Managers should audit care plans to ensure initial care plans are completed within 48 hours of admission.

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.

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

Multidisciplinary team (MDT)
Isla Ward currently has input from four consultant psychiatrists who cover the catchment area. There is additional input from a further four consultant psychiatrists who have patients boarded in from adult services.

There is regular input from occupational therapy (OT), psychology, physiotherapy, and pharmacy, all who attend the MDT meetings. We heard that social work referrals are made early in the admission process, and social work departments are responsive.

Input from other professionals, including speech and language therapy and dietetics are arranged on a referral basis. There is also input from two advanced nurse practitioners who work across the mental health campus.

There have been several recent appointments to the nursing team, with vacancies still to be recruited to for one registered nurse and two health care assistants. We heard that as well as the mandatory training being undertaken by staff, assessment training is about to commence and there are plans to train several staff in the management of stress and distress.

We found the MDT meeting notes were detailed, and they included clear decisions, along with any actions that were required and who was responsible for completion of these.

Patients, relatives and carers were invited to attend MDT meetings. If relatives were unable to attend meetings, staff proactively contacted them to provide feedback and this was documented in the chronological notes. Discharge planning was documented and community team members attend discharge planning meetings.

On the day of the visit, there were three individuals who had been identified as having their discharge from hospital delayed; they were managed through regular reviews at the MDT meeting. We heard that additional meetings took place regularly with senior managers and the clinical team, including service managers and commissioning services, the delayed discharge coordinator, and the hospital flow coordinator, who meet with the team to review and expedite the discharge process.

Use of mental health and incapacity legislation

On the day of the visit, ten people were detained under the Mental Health Act. All documentation relating to the Mental Health Act was in place.

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

Where an individual had granted a POA or was subject to a guardianship order, details of powers granted, and the contact details of the proxy should be held on file. We found copies of one POA on file, however from our observations, and discussions with staff, this information is not routinely requested on admission and recorded.

Recommendation 2:
Managers should ensure that information in relation to proxy decision makers is sought and recorded on admission.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate 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. At the time of our visit only one individual required a section 47 certificate. This certificate was out of date, having expired two days previously; this was raised with the SCN on the day.

Recommendation 3:
Managers should ensure that staff are aware of the requirements of the AWI Act.

Rights and restrictions

Entry to the ward is managed by staff and exit is controlled by a keycode; this is commensurate with the level of risk identified in the patient group. Information on how to enter and exit the ward was available near the door. The ward has open visiting.
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 person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we reviewed this for those who were subject to this restriction. We found that the paperwork and the reasoned opinion were in order.

Information on advocacy services are contained in Isla Ward's admission information leaflet. We found evidence in the care records of advocacy services being offered and accessed by patients.

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.

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

Activity and occupation

The ward has input from two therapeutic activity nurses who provided a comprehensive activity programme. There was activity provision throughout the day, including a wide variety of group and individual activities which people could choose to attend, such as relaxation groups, quizzes, pamper sessions, reminiscence, musical activities, crafts and games.

There were evening and weekend activities, with regular outings to local community facilities and groups using the minibus. We were told about the volunteers who provide therapet visits, input in the gardens and assisted with musical and craft activities. Throughout our visit, we also saw members of nursing staff involved in small group activities such as dominoes or just chatting with people.

We were pleased to find meaningful recording of participation and the outcome of activities in the records we reviewed.

The physical environment

The ward is comprised of two four-bedded bays, two two-bedded rooms and 12 single en-suite rooms. There are showers and toilets off each of the shared spaces.

There are also two large bathrooms with shower and toilet facilities, however one of these was being used to store hoists and mobility equipment. There are two large sitting areas, a dining area, a quiet lounge, and an additional activity room off the ward foyer.

The ward is bright and spacious, and the décor is good. Murals and pictures of local Glasgow scenes around the ward added interest to the environment, as do the memory walls. There are well-designed, secure gardens with plenty of seating; the atmosphere in the ward was warm and welcoming. There were several quiet spaces as well as the large sitting areas.

In our previous two visit reports to Isla Ward, we made recommendations in relation to the ensuite bathroom doors. We were told that despite the heavier magnets now used the doors are still easily detached and can compromise the safety of patients We were told they are all that is available and people who wish to have them in place do have them, however in several of rooms they were absent, thereby compromising the dignity and privacy of people.

Recommendation 4:
Managers must urgently address the provision of suitable and safe ensuite doors to protect the safety and dignity of people.

Summary of recommendations

Recommendation 1:
Managers should audit care plans to ensure initial care plans are completed within 48 hours of admission.

Recommendation 2:
Managers should ensure that information in relation to proxy decision makers is sought and recorded on admission.

Recommendation 3:
Managers should ensure that staff are aware of the requirements of the AWI Act.

Recommendation 4:
Managers must urgently address the provision of suitable and safe ensuite doors to protect the safety and dignity of people.

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.

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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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