Mental Welfare Commission for Scotland

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

Date of visit: 12 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

Elgin Ward is a 20-bedded unit in Stobhill Hospital that provides acute mental health admission for individuals under the age of 65 years old.

Elgin Ward also supports the ESTEEM mental health service, for individuals aged between 16 and 35 years old, who are experiencing a first episode of psychosis.

On the day of our visit, there were 20 people on the ward and no vacant beds.

We last visited this service in June 2024 on an unannounced visit and made recommendations in relation to person-centred care planning, authority to provide care and treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). We also made recommendations to ensure drainage issues in the ensuite bathrooms were repaired timeously.

The response we received from the service was that care records, including person-centred care plans and authority to provide care and treatment, were being audited, and that drainage issues had been resolved.

On the day of this visit, we wanted to check any progress made in relation to previous recommendations. We also wanted to look at issues that had an impact on care and treatment, including the implementation of updated policy and procedure in relation to risk assessment and communication with families and/or unpaid carers.

Who we met with

We met with nine people, reviewing the care for seven of these individuals and reviewed the care notes of one further person. We also met with one relative on the day of our visit.

We spoke with the senior charge nurse (SCN), a charge nurse (CN), a staff nurse (SN) and the service manager (SM).

Commission visitors

Gemma Maguire, social work officer

Karen Beattie, nursing officer

Mark Richards, nursing officer

What people told us and what we found

Everyone we met with on the day of our visit spoke positively about staff and the care they were receiving on Elgin Ward.

Individuals told us staff were “nice”, they felt “listened” to and that “things have been a lot better” recently. We heard about recent changes in staff across Elgin Ward, including the SM, the SCN, and the CNs. We met with the new management team on the day of our visit and heard that changes had been challenging, but considerable work had been done which had improved communication across the multidisciplinary team (MDT).

We were also advised that auditing of care records had identified several areas for improvements which the team were working on, including quality of recording and ensuring records reflected the person-centred care being delivered. We found staff and managers in Elgin Ward to be reflective and motivated in support of change to improve the service for individuals.

Individuals and one relative we met with told us the recent staff changes had brought “big improvements” for people on the ward. We heard that previously there were “unnecessary rules and restrictions which felt unfair” for many individuals. An example that was given on previous restrictions included the removal of televisions from bedrooms and/or counting of cutlery after each mealtime, regardless of individually assessed risks. People told us that since these changes had been made, staff were “working together”, and communication with individuals and/or their families was “much better”.

At the time of our last visit to the service, several individuals with a diagnosis of autism and/or learning disability were being cared for in Elgin Ward; this was due to shortages in the availability of specialist inpatient beds. We were pleased to find that the service had supported many of these individuals to progress onto specialist inpatient services or be discharged to appropriate support in the community.

On the day we visited Elgin Ward, no one had been admitted to the service due to bed shortages in other areas of the service. Several care records we reviewed evidenced recovery-focussed MDT assessment and planning to support individuals to be discharged and transition on.

Several people we met with told us how input from psychology had been helpful in developing their understanding of trauma and mental health. The SM told us the service had a full complement of psychology staff and plans were progressing for psychology to review individuals who were subject to more restrictive practices, such as continuous intervention; the service hoped this would minimise the need for this.

On the day of our visit, we were pleased to find consultation happening with individuals and families, with support from a local mental health network. The network gathered views from individuals which the service told us they intended to fully consider in relation ongoing improvements.

Care, treatment, support, and participation

Care records

Since our last visit to Elgin Ward there had been some improvement in the recording of person-centred care plans. Several plans we reviewed covered individuals' needs in relation to physical and mental health, were reviewed timeously, and had clear details of progress being made in relation to recovery-focused goals.

We were pleased to find that most care plans recorded the views of individuals, family or unpaid carers, evidencing meaningful consultation in line with local policies and procedures.

We did find one person's care plan had not been reviewed or updated since November 2025. We discussed this with the SCN and a CN on the day of our visit. We were advised that work was underway to ensure all care plans were reviewed timeously. We heard how an improved audit process had recently been implemented and were assured this issue would be addressed. We look forward to reviewing the continued progress made by the service in relation to person-centred care plans when we next visit.

Each care record we reviewed had risk documentation in place. We found one document had not been reviewed following an increase in the risk of harm. We found risk documentation to have chronologies detailing historical risks, however there was little information recorded in relation to what risk assessment had been undertaken and how each individual risk should be managed. We discussed these issues with the SCN on the day of our visit who welcomed our feedback and informed us that auditing of risk documentation and quality of information being recorded will be progressed.

Recommendation 1:
Managers responsible for Elgin Ward should audit risk documentation to ensure it is regularly reviewed, and contains current, individualised information in relation to risk assessment and risk management.

Multidisciplinary team (MDT)

The MDT consisted of nursing staff, consultant psychiatrists, resident doctors, pharmacy, occupational therapy (OT), and psychology. Referrals were also made to other services, such as social work, physiotherapy and speech and language therapy, when required. We found that MDT meetings were held weekly and individuals and

their families were invited to attend, with their views noted in the records for the meeting.

Most MDT records had detailed notes of who attended, with clear action points relating to person-centred care plans and risk documentation. However, we found the quality of recording to be inconsistent, with some records lacking details of what was discussed or the actions that were agreed at the meeting. We discussed this with the SCN on the day of our visit and were advised the service were aware of these inconsistencies and raising this with disciplines across the MDT.

Recommendation 2:
Managers in Elgin Ward should audit MDT records to ensure discussions and agreed actions which relate to individualised goals are consistently recorded.

Use of mental health and incapacity legislation

On the day of the visit, 11 people were detained under the Mental Health Act; all individuals who were detained were aware of their rights. Several individuals were receiving legal advice and accessing advocacy services.

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) were in place and corresponded with the medication being prescribed. We found that one person's certificate authorising their treatment (T3) under the Mental Health Act was not available in their care records. We informed the SCN of this on the day of our visit who escalated to the person's responsible medical officer to ensure the document was added to records.

Recommendation 3:
Nursing and medical staff on Elgin Ward should ensure that all certificates authorising treatment under the Mental Health Act are accessible in individual care records.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Several individuals had nominated a named person and where they had done so, we found documentation to be accessible and the named person to be appropriately consulted.

One person we met with and reviewed care records for was subject the AWI Act and information about a power of attorney was clearly documented in their records. We did not find a copy of the power of attorney document. We provided advice to the SCN on the day of our visit to ensure this is requested from the attorney and stored securely in 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. One individual we reviewed on the day of the visit had a section 47 certificate in place. We met with and reviewed another individual whose physical health had recently declined and nursing staff were querying the persons decision-making capacity regarding medical needs. We provided advice to the SCN on the day of our visit, to ensure these concerns were discussed and assessed by an appropriate doctor, and where appropriate, a s47 certificate should be issued.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit one person in Elgin Ward was specified under the Mental Health Act, and we found the relevant documentation to be in place.

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 no advance statements in place in the care records we reviewed.

The template used by the service to record MDT meetings referred to advance statements, but there was no evidence that meaningful discussions were taking place with individuals about completing and/or reviewing statements during these meetings. We discussed this with the SCN on the day of our visit and agreed that with the MDT template already in place, it provided an opportunity to promote the benefits of advance statements or to review statements already in place. We received assurances that these discussions would be recorded and would expect to see evidence of this on our next visit.

Activity and occupation

During our visit to Elgin Ward, we heard how individuals valued the availability of therapeutic and leisure-based activities. People we met with told us that the therapeutic activity nurse and OT services were beneficial to their recovery.

We found evidence of meaningful activities being undertaken with individuals on a daily basis. These including access to a wellbeing hub, community vocational placements, a gym or participating in music groups and Tai Chi classes.

Several individuals we met with were involved with OT services, where functional assessments had been carried out to support discharge planning. Psychology services were also providing formulations which helped to support individuals to engage in recovery focussed activities.

The physical environment

Elgin Ward was bright and spacious with room for activities, receiving visitors, TV/Lounge, and dining areas.

All bedrooms were ensuite, and individuals could access a well-maintained outdoor garden area. We were pleased to report that the drainage issues we found in some of the ensuite bedrooms during our last visit to Elgin Ward had been resolved.

Summary of recommendations

Recommendation 1:
Managers responsible for Elgin Ward should audit risk documentation to ensure it is regularly reviewed, and contains current, individualised information in relation to risk assessment and risk management.

Recommendation 2:
Managers in Elgin Ward should audit MDT records to ensure discussions and agreed actions which relate to individualised goals are consistently recorded.

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Nursing and medical staff on Elgin Ward should ensure that all certificates authorising treatment under the Mental Health Act are accessible in individual care records.

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