mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Leverndale Hospital, Ward 3A, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 24 March 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

Ward 3A is an adult acute mental health admission ward that covers the geographical area of south Glasgow, including Barrhead, Pollock and Crookston. The ward has 24 beds and is divided into two inpatient areas that have single and dormitory bedrooms.

We last visited this service in November 2023 on an announced visit and made recommendations in relation to ensuring copies of welfare guardianship powers were stored in files, and section 47 certificates were issued to appropriately authorise medical treatment for individuals.

On the day of this visit, we wanted to follow up on the previous recommendations and look at any other issues relating to care and treatment.

Who we met with

We met with 10 people and reviewed the care notes for five of these individuals. We also reviewed the care notes of a further two people.

We spoke with the service manager (SM), charge nurses (CN), a bank nurse and a student nurse.

Commission visitors

Gemma Maguire, social work officer

Sheena Jones, consultant psychiatrist

Graham Morgan, engagement and participation officer

What people told us and what we found

We heard from those individuals that we met with that staff were ‘kind’ and ‘supportive’. We were also told that staff take time to ‘sit and listen’ and how this helps people to feel ‘validated’.

On the day we visited the service, many individuals were experiencing acute symptoms of mental disorder causing them to feel distressed. We observed nursing staff respond to individuals who were in distress with compassion and care.

At the time of our last visit, we heard from an individual who was receiving care and treatment in relation to an eating disorder; they told us that they felt some staff did not fully understand their needs. During that visit we discussed staff training, support and experience around supporting individuals with this illness and were informed that several nurses, who had experience in supporting individuals with eating disorder, had left the service with many newer members of staff joining the team. We were informed that training would be progressed for all nursing staff in relation to supporting individuals with eating disorder. We were pleased to hear that during this visit, training in relation to eating disorder has progressed on a ‘rolling’ program basis and that staff receive support during supervision sessions. We were also pleased to hear that in-reach specialist eating disorder services, as well as access to dietitians and psychology, continues to support individual recovery. Some individuals we met with during this visit were receiving care and treatment in relation to an eating disorder and informed us that they feel supported by staff.

Many of the individuals we met with were aware of their rights, had access to legal advice and were either involved with advocacy or knew how to access this service. We are pleased to hear that individuals could participate in the day-to-day running of the ward via the community team meetings.

During our visit no relatives were available to meet with us and we were advised that families and/or carers could attend a monthly carers group meeting to provide feedback, as well as this being an opportunity to share information.

Some individuals we met with told us that after 7.30pm, their access to the garden is limited. We discussed with CNs and SM on the day of our visit, who advised that access to the garden area should not be restricted until 10pm which is in line with the wider hospital health and safety policy. We were advised that staff would investigate these reports further and ensure individuals were able to access the gardens during these times.

CNs advised the Commission visitors that there were good links with social work and community mental health teams to support individuals’ discharge from hospital. On the day of our visit, we reviewed the care notes of two individuals whose discharge from hospital was delayed. We found that discharge plans for these

individuals were progressing, with records detailing the reasons for the delays, including provision of appropriate legal safeguards, accommodation and/or support services.

On the day of our visit, we were advised that nine individuals were admitted and/or transferred to Ward 3A due beds being unavailable in the service attached to the area in which they live. In discussion with CNs, we were informed that these individuals were cared for by Ward 3A nursing staff, however this differed to the inpatient consultant psychiatrist (CP). We heard how this could, at times, make communication and contact with psychiatry inconsistent. From speaking with individuals and/or reviewing care records, we found that people were meeting with the CP on a regular basis and there was good communication between the MDT.

We met with a student and a bank member of nursing staff during our visit and heard how they have both enjoyed working in the service, with the bank nurse deciding to return to the ward several times. The student nurse explained this was their first placement and the service has been 'very supportive' of their learning. They also informed us that the placement has provided them with 'great' experience in learning to engage with people receiving care and treatment on the ward.

Care, treatment, support, and participation

All care records, including care plans, multidisciplinary (MDT) records and risk assessments, were accessible on the electronic recording system, EMIS. We found individual risk assessment documents to be appropriately in place and reviewed.

We found that care plans and reviews were updated, with good information about the persons progress in their recovery. Individuals could decide on whether they consented to information being shared with family.

When reviewing care records, we found that staff where appropriately recording the views of individuals and respecting their choice about information sharing. We found some care plans had not recorded the views of families, despite them being actively involved. The Commission is of the view that where family and/or carers are involved, services should listen and record their views, even if information cannot be shared about their loved one.

Many individuals we met with were not aware of, nor had they seen a care plan document, although they appeared to understand their individual goals. We found the language used in some care plans was nurse-orientated as opposed to being led by the person. We discussed the issues around person-centred care planning with CNs and SM on the day of our visit and were advised our feedback will be considered as part of audit processes.

Recommendation 1:
Managers responsible for Ward 3A should carry out an audit of person-centred care plans to ensure they use individualised language, are accessible to individuals, with the views of individuals and their families clearly recorded.

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)
MDT meetings continue to be held weekly and consist of the CP, psychology, pharmacy, occupational therapy (OT), physiotherapy and patient activity co-ordinator (PAC) nurse.

We found that records of MDT meetings recorded who attended and had clear actions relating to care plans. The record of meetings also recorded the views of individuals and their families.

Use of mental health and incapacity legislation

On the day of the visit, 15 people in ward 3A were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (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 given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. We found one person did not have prescribed medication on a certificate authorising their treatment (T3) under the Mental Health Act. We fed this concern back to the CN and CP for action.

Recommendation 2:
Medical staff in Ward 3A should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

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

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

At the time of our last visit, we made a recommendation for managers to ensure that individuals who were subject to welfare guardianship under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), had copies of certificates detailing powers in their care records.

We met with and reviewed the care records for one individual who was subject to welfare guardianship. There was no copy of the certificate in relation to powers granted available in their records. The Commission are of the view that staff supporting individuals who are subject to the AWI Act, should be aware and understand any powers which have been granted.

We discussed this with the CN on the day of our visit who agreed to request a copy of the certificate from the welfare guardian.

Recommendation 3:
Managers responsible for Ward 3A should ensure that copies of documentation relating to individuals who are subject to the AWI Act, including welfare guardianship, are available in care records, with details of powers granted.

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. For the individuals we reviewed who were subject to a section 47 certificate, we found these to be appropriately in place.

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 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.

On the day of our visit, one person in Ward 3A was specified under the Mental Health Act. We reviewed the care records for this person and found that there was no reasoned opinion recorded in relation to imposing the restrictions. Whilst the individual had been verbally notified about restrictions, we found that they had not been provided with written information about the restrictions in place, review timescales or in relation to their rights.

We discussed these issues with the CNs and SM on the day of our visit, who advised this would be escalated for action and reviewed as part of an audit process. We also wrote to the CP with information and advice regarding specified persons which they noted.

Recommendation 4:
When someone is made a specified person, medical staff should ensure a reasoned opinion is provided for imposing restrictions, and that individuals are given written information about the restrictions in place, timescales for review and in relation to their rights.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[2].

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. Where individuals had an advance statement in place, the electronic system provided an alert to ensure staff reviewing the person's record were aware.

We found some evidence that advance statements were being discussed in MDT meetings, but this was not consistent. In discussion with CNs, we were advised that nursing staff and advocacy services support individuals to complete an advance statement whenever it is appropriate to do so. Information about advance statements was also available on the ward notice boards.

The Commission has developed *Rights in Mind.*[3] 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

Group based and individual activities on Ward 3A are supported by an onsite recreational therapy centre (RT), PAC nurse and OT service. Activities include art groups, creative writing, football and walking groups.

We heard from several people that we met with that they had a good choice of activities both at the RT centre and on the ward. We were told that the PAC nurse is 'phenomenal'.

Some people we met with felt there could be more activities when the PAC nurse is not available. We discussed this with the SM and CN who informed the PAC nurse works five days over seven to maximise the provision of activities, given the RT

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

centre is not open on weekends. We were also advised that nursing and OT staff support activities when PAC nurse is not available.

The physical environment

Ward 3A has two single ensuite bedrooms, with most individuals accommodated in shared dormitories. We met with one individual who informed us that sharing a dormitory was 'difficult' and 'noisy'.

When previously visiting the service, we have heard of similar experiences regarding dormitories, while other people have reported to enjoy sharing a bed space. The environment remains an ongoing challenge for staff to prioritise space based on individual need and risk assessment. As discussed in our previous visits, issues can only be changed by reconstruction and redesign of the environment.

At the time of our last visit to the service, people told us the ward was tired looking. During this visit individuals we met with informed the environment appeared 'run down'. We noted that an interview room had a large hole in the internal wall and would agree that the ward would benefit from work to improve the inside décor and appearance.

We discussed these issues with the CNs and SM on the day of our visit, who also agreed with the comments made regarding the inside appearance of the ward. The SM informed us these issues continue to be escalated in the service. We were also advised that the damage to the interview room wall is awaiting repair.

Recommendation 5:
Managers responsible for Ward 3A should ensure that work is undertaken timeously to improve the interior décor.

On the day of our visit, we observed individuals smoking in the communal garden area. The Commission are aware that the law has changed, and it is not lawful for anyone to smoke in hospital grounds in Scotland. We were informed that individuals are advised not to smoke on hospital grounds and that nicotine replacement therapy (NRT) is available, however some people continue to smoke in the areas outside the wards. The Commission are clear 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 inpatient services are enforcing smoking bans and utilise NRT.

Recommendation 6:
Managers of Ward 3A should ensure that legislation and local procedures are adhered to in relation hospital buildings being smoke free.

Summary of recommendations

Recommendation 1:
Managers responsible for Ward 3A should carry out an audit of person-centred care plans to ensure they use individualised language, are accessible to individuals, with the views of individuals and their families clearly recorded.

Recommendation 2:
Medical staff in Ward 3A should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

Recommendation 3:
Managers responsible for Ward 3A should ensure that copies of documentation relating to individuals who are subject to the AWI Act, including welfare guardianship, are available in care records with details of powers granted.

Recommendation 4:
When someone is made a specified person, medical staff should ensure a reasoned opinion is provided for imposing restrictions, and that individuals are given written information about the restrictions in place, timescales for review and in relation to their rights.

Recommendation 5:
Managers responsible for Ward 3A should ensure that work is undertaken timeously to improve the interior décor.

Recommendation 6:
Managers of Ward 3A should ensure that legislation and local procedures are adhered to in relation hospital buildings being smoke free.

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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