Mental Welfare Commission for Scotland

Report on unannounced visit to:
Leverndale Hospital, Ward 4A and Ward 4B, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 10 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 4A is an adult acute, mental health admission ward and covers the geographical area of Eastwood, Barrhead (East Renfrewshire) and Castlemilk (Glasgow City). The ward has 24 beds and is divided into two in-patient areas that has single rooms with en-suite facilities.

Ward 4B is an adult acute, mental health admission ward and covers the geographical area of Govan and Ibrox (Glasgow City) and Cambuslang and Rutherglen (South Lanarkshire). This ward also has 24 beds and is divided into two in-patient areas that has single rooms with en-suite facilities. Ward 4B support the ESTEEM mental health service, for individuals aged between 16 and 35 years old, who are experiencing a first episode of psychosis.

We last visited this service in November 2023 on an announced visit and made recommendations in relation to accessibility and storage of care plans, review of risk assessment, authorisation of medical treatment, provision of activity over seven days, and ensuite magnetic doors impacting individual rights to privacy and dignity.

The response we received from the service was that care plans were being stored electronically with care records, including risk assessment and consent to medical treatment documentation was being regularly audited. We were also informed that staff try to provide activities on weekdays as well as at weekends, and that the use of magnetic ensuite doors will continue for safety reasons.

On the day of this visit, we wanted to follow up on the previous recommendations and look at any other issues that may have had an impact on care and treatment.

Who we met with

We met with 11 people and reviewed the care records of nine of these individuals. We reviewed the care records of a further two people and joined ward 4B community meeting which was attended by 11 individuals. We also met with one relative.

We spoke with the service manager (SM), senior charge nurses (SCN), charge nurses and patient activity co-ordinator (PAC).

Commission visitors

Gemma Maguire, social work officer

Mary Hattie, nursing officer

Graham Morgan, engagement and participation officer

Anne Craig, social work officer

Audrey Graham, social work officer

What people told us and what we found

We heard from those that we met with that staff make them feel 'safe' and 'go out their way' to help. We were invited to join a community meeting which was facilitated by PAC nurse and attended by 11 individuals from Ward 4B. We observed individuals participating and openly asking questions about the service, including food choices and repairs required on the ward. We were pleased to see that individuals who felt unable to speak out at the meeting, were encouraged to discuss any concerns and/or provide feedback during one-to-one time with staff.

One relative we met with told us that staff knew their loved one 'really well' and that they always feel 'listened' to. They informed us that the 'understanding' approach taken by staff was important in developing trust with the individual and with them. We were pleased to hear that family and/or carers can attend a monthly carers group meeting. Several staff members we met with told us about the importance of consulting and seeking views from family and/or carers to support someone's recovery, whilst respecting an individual's choice regarding their decision not to have information shared; the Commission would agree this is good practice.

On the day of our visit, we were advised that Ward 4A had experienced an increase in the number of individuals who required continuous interventions. We were also made aware that in both Ward 4A and 4B, some individuals experienced complex difficulties in relation to their mental health, physical health, intellectual disability and/or autism. We are pleased to note that throughout our visit we observed staff managing the competing demands of these issues in order to ensure an individual's safety, while providing a high level of considerate and compassionate care.

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.

The SCNs advised us that the services have good links with social work and community mental health teams to support individuals who are being discharged from hospital. On the day of our visit, we reviewed the care records of two individuals who were delayed with their discharge from hospital. We found that discharge plans for these individuals were progressing appropriately and the records detailed the reasons for delays, including where there was the provision of appropriate legal safeguards, and information on accommodation and/or support services.

Care, treatment, support, and participation

All care records, including care plans, multidisciplinary team (MDT) records and risk assessments, were accessible on the electronic recording system, EMIS. We are pleased to find that during this visit, individual risk assessment documents were detailed and reviewed.

We found care plans in Ward 4A to be person-centred and consistently reviewed, with the views of individuals and/or their families clearly recorded.

While we found evidence of person-centred care plans and reviews in Ward 4B, the quality of what was recorded was variable. We found that some plans had not recorded the views of individuals and/or their families, despite people telling us they had been consulted.

We reviewed the care records for one individual who had communication and sensory needs. In discussion with staff, they demonstrated a good understanding of the persons communication and sensory needs, however this information was not detailed in their care plan. We discussed these issues with the SCN on the day of our visit, who advised us that they had only recently started working on the ward and that their plan was to support staff by rolling out care plan audits, as well addressing individual training issues in supervision. We look forward to seeing improvements in relation to the quality and consistency of person-centred care planning in Ward 4B.

Recommendation 1:
Managers responsible for Ward 4B should carry out an audit of nursing care plans to ensure they address individual needs, with the views of individuals and their families appropriately 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 consultant psychiatrists (CP), psychology, pharmacy, occupational therapy (OT), physiotherapy and PAC nurse. We were pleased to find that there was regular input from psychology services, including individual and group sessions.

We found that records of the MDT meeting had clear actions, with the views of individuals and their families and/or carers recorded. Unfortunately, the recording of who attended meetings was not consistent. We discussed with SM, SCN and CN on the day of our visit and were advised that auditing of these records will be progressed.

Recommendation 2:
Managers for Wards 4A and 4B should audit MDT records to ensure they record everyone in attendance.

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

Use of mental health and incapacity legislation

On the day of the visit, 14 people in Ward 4A and 17 people in Ward 4B 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) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

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

For those people that were under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) we did not find documentation that we would expect to see, such as copies of welfare guardianship certificates with details of specific powers. On the day of our visit, we noted that the term 'AWI' was often used to refer to different sections of the AWI Act, such as welfare guardianship. The Commission would advise that relevant sections of the AWI Act are specifically recorded, to avoid any confusion regarding legal safeguards. We discussed with SCNs on the day of our visit and shared the Commission and NHS education for Scotland online learning resources in relation to the AWI Act.

Recommendation 3:
Managers responsible for Ward 4A and 4B should ensure that copies of documentation relating to individuals who are subject to the AWI Act, such as welfare guardianship certificates, are available 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. For the individuals we reviewed who were subject to a section 47 certificate, we found these to be 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 4A and two people in Ward 4B were specified under the Mental Health Act. We reviewed the care records of these individuals and found that a reasoned opinion had been recorded in relation to the restrictions that were in place. While individuals had been verbally advised about the restrictions, we found that they had not been provided with written information regarding what was specifically restricted, including information about reviews and their right of appeal. We discussed these issues with the SCN and SM on the day of our visit and were advised that concerns would be escalated to CP for action.

Recommendation 4:
When someone is made a specified person, medical staff should provide individuals with written information regarding restrictions imposed, timescales for review and information about 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 do or do not want. Health boards have a responsibility for promoting advance statements. We did not find any copies of advanced statements but were advised that information on writing an advance statement is provided by ward staff and supported by advocacy services.

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 Wards 4A and 4B are supported by an onsite recreational therapy centre (RT), PAC nurse and OT service. Several individuals we met with told us they 'had enough to do', and that RT centre and/or PAC nurses were 'excellent'. Activities include art groups, creative writing, football and walking groups. During this visit, we were impressed to find feedback and preferences from individuals were incorporated into activity plans, with a focus on reconnecting

[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

individuals with their past interests. We met with several staff who were motivated and committed to engaging people in meaningful activities.

At the time of our last visit to the service we commented on the lack of activity provision available over seven days per week. During this visit, one person we met with told us that on days the PAC nurse is not working there is 'less to do'. We discussed the provision of activities over seven days per week with SCNs for Ward 4A and 4B, who acknowledged that support for activities over weekends is mainly provided by nursing staff, which at times can be difficult to balance with clinical demands. We are disappointed to hear this remains an issue and we will continue to follow this up with the service.

Recommendation 5:
Managers should ensure that individuals have access to meaningful activity and occupation seven days per week.

The physical environment

Ward 4A and 4B both have single ensuite rooms, dining and lounge areas, smaller interview rooms and an activity room. The wards share a communal entry area and are purpose-built with identical layouts. On the day of our visit, we found both wards to be clean and bright.

At the time of our last visit to the service we were concerned about individual rights to privacy and dignity due the use of ensuite saloon style doors, which were reported to fall off and only partially cover bathrooms. We were advised that following extensive health and safety review by the service, the use of these doors will continue but that heavier weights have been installed to prevent them falling off. During this visit no one we met with raised any concerns about the ensuite doors.

On our last visit to the service, we met with several individuals who had a diagnosis of autism. At that time, we heard that the ward environment can be a difficult sensory experience. During this visit we met with one individual who told us they can find the environment of Ward 4B 'noisy', particularly in communal areas. They advised that whilst they feel staff were 'supportive' and they have access to a sensory room, although there are not enough quiet areas on the ward.

We discussed these issues with the SCN and PAC on the day of our visit and were advised that several individuals in Ward 4B have autism in addition to experiencing mental health difficulties. We heard how staff try to support the sensory needs of individuals as best they can but that maintaining a calm and quiet environment in an acute adult admission ward can be challenging. The SCN and SM informed us that plans were progressing for a sensory garden in the ward outdoor area, as well exploring more specialised training for staff in supporting autistic people. We look forward to hearing about progress in these areas.

On the day of our visit, we observed individuals smoking in the communal garden areas. The Commission advised the services 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 continued to smoke in the areas outside the wards. The Commission were 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 utilised NRT.

Recommendation 6:
Managers of Ward 4A and 4B 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 4B should carry out an audit of nursing care plans to ensure they address individual needs, with the views of individuals and their family and/or carers appropriately recorded.

Recommendation 2:
Managers for Wards 4A and 4B should audit MDT records to ensure they record everyone in attendance.

Recommendation 3:
Managers responsible for Ward 4A and 4B should ensure that copies of documentation relating to individuals who are subject to the AWI Act, such as welfare guardianship certificates, are available in care records.

Recommendation 4:
When someone is made a specified person, medical staff should provide individuals with written information regarding restrictions imposed, timescales for review and information about their rights.

Recommendation 5:
Managers should ensure that individuals have access to meaningful activity and occupation seven days per week.

Recommendation 6:
Managers of Ward 4A and 4B should ensure that legislation and local procedures are adhered to in relation hospitals 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.

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.

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