Mental Welfare Commission for Scotland

Report on announced visit to:
Leverndale Hospital, Ward 2, 510 Crookston Road, Glasgow, G53 7TU

Date of visit: 6 August 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 2 is a 15-bedded, mixed-sex continuing care ward for people with severe and enduring mental ill health, which forms part of the rehabilitation service in Leverndale Hospital.

On the day of our visit, there were 15 people in the ward and no vacant beds. Approximately five people in the ward were general adult psychiatry patients who were temporarily placed in Ward 2 due to a lack of available beds in the relevant service. We heard from the senior charge nurse that this had been a recurring issue over the last 12 months and that efforts were made to ensure that all people in the ward had regular contact with their multidisciplinary teams (MDT).

Some people had been in Ward 2 for many years, due to their significant ongoing mental ill health. At the time of our visit there were no people in the ward who were considered to be 'delayed discharges' which means when people are considered to be ready to leave hospital and no suitable place had been identified for them to move to.

We last visited this service in May 2023 on an announced visit and made six recommendations. These included auditing of person-centred care plans and do not attempt resuscitation forms, recording of Care Programme Approach minutes and adults with incapacity documentation in the electronic care records, training to staff about advance statement certificates, and planning for single room accommodation in the service.

We were told by senior staff that a new person-centred care plan had been introduced across the service earlier this year. We heard that the care plans had recently been audited and had scored well. We heard that all meeting documentation was available in either paper or electronic form and that do not attempt resuscitation forms had been audited. We were told that training had been provided to staff in relation to advance statement completion, but it was also noted that many people in the service did not have the capacity to complete an advanced statement due to their mental ill health. With regards to single room accommodation, we heard that there were no current plans in relation to this, due to financial constraints.

On the day of this visit, we wanted to follow up on the previous recommendations and to hear from people, families and carers about their care and treatment in Ward 2.

Who we met with

We met with, and reviewed the care of seven people, five who we met with in person and seven who we reviewed the care notes of. We also met with/spoke with one relative.

We spoke with the service manager (SM) and the senior charge nurse (SCN). In addition, we met with a British Sign Language interpreter who regularly visited the ward.

Commission visitors

Mary Hattie, nursing officer

Dr Sheena Jones, consultant psychiatrist

What people told us and what we found

One person told us that the nursing staff here “are good” and helped with food. They said that they saw their doctor often and that they asked them questions. They said that they were given tablets for their head and that “the tablets are good.” The same person spoke about being kept in hospital and being worried that they would never leave. We heard from the person’s interpreter that they had supported them to speak with advocacy services and to make an appeal to the mental health tribunal about their compulsory treatment.

One relative told us that the care and treatment in Ward 2 was “exceptional”. They spoke about their concerns that their relative had been neglected in their previous ward and were considering making a formal complaint with this regard to this. In contrast, they said that from the very beginning of their stay in Ward 2, their relative had received proper care and that the staff team had a “complete focus on the whole person”. They spoke about the staff team getting to know people and their caring, welcoming and responsive approach. They told us that they were regularly contacted by their relative’s psychiatrist and kept fully up to date by the MDT.

We were grateful to the nursing team for their help on the day of our visit. It was clear that they knew the people in the ward well and we saw warm and caring interactions with people during our visit and sensitive and professional interactions with people at times when they were distressed.

Senior staff told us that there had been no significant incidents and no formal complaints since our last visit.

We heard from the senior charge nurse about a recent adult concern in relation to a person talking about inappropriate sexual behaviour involving nursing staff in Ward 2. We heard that the police had been involved, and an adult concern form had been completed under Adult Support and Protection (Scotland) Act, 2007. We heard that the person involved needed support with communication and that they had been supported with an interpreter to express their concerns; it became clear that there had been a miscommunication. There were no ongoing police or ASP processes in regard to this. The person’s family had been fully involved, and the senior charge nurse advised us that they had been reassured by the robust approach taken and had no ongoing concerns.

Care, treatment, support, and participation

Care records

Care records were held on an electronic system called EMIS in Ward 2, with some specific documentation such as mental health and adults with incapacity act forms also held in paper files.

We found the electronic system easy to navigate and we were able to find all the information that we required including people's care plans, daily progress notes and minutes from ward meetings.

We saw a range of information in the care records in relation to people's mental and physical health, mobility and activities. We saw regular completion of risk assessments which were person-centred and completed when there were concerns about both mental and physical health.

A standard person-centred care plan (PCCP) template had been introduced across the local service earlier this year; we could see that everyone had a PCCP in their electronic record and that these were being regularly reviewed. The PCCP had sections relating to physical health, mental and psychological health, substance and alcohol use, social needs, legislation and legal aspects of care and spiritual needs.

We saw that PCCPs contained specific information for all relevant sections for each individual, but the actions were often focussed on what the nursing team needed to achieve rather than on the wishes and goals of each person. We also saw that the actions were in relation to broad themes and lacked specific goals that could be achieved over a set period of time and which would show each person's progress over time.

We found that there was a lack of consistency in how the PCCPs were completed for each person. In some cases, the care plans were updated with current information, but in a number of cases we had to read through pages of reviews to find information about the person's current care. In one case this meant that the person's levels of support were not accurately recorded in the main section of the care plan. For another person the care plan provided detailed information about the person's mental health at the time of their admission a number of months before and had not been updated to reflect their improved mental and physical health and progress towards rehabilitation.

Recommendation 1:
The service manager and senior charge nurse should review the person-centred care plans to ensure that the care plans are up to date, consistently completed, with clear goals to be achieved over a set period of time, and with a focus on the individual.

In some cases, we could see that the views of the individual or their families and carers had been included in the PCCPs, but there was, in general, a lack of detail with regards to the specific goals that they may wish to achieve. We spoke to the senior charge nurse and heard that it could be difficult to involve people in their care plans when they were unwell or did not wish to engage. We spoke about positive examples where care plans included detail in the person's own voice and how valuable that

was. We also heard that there had been a recent audit of the person-centred care plans and that Ward 2 had performed well, despite the issues we had found.

Recommendation 2:
Senior managers should review the care plan audit tool to ensure that it is effective in supporting good practice in person centred care planning.

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.

We have made recommendations about the completion of do not attempt resuscitation (DNACPR) forms on two previous visits to Ward 2. We reviewed all DNACPR forms in Ward 2. These were kept in paper form in the ward office. In most cases, the forms were up to date and evidenced that there had been discussion with welfare proxies or family members. In one case, the DNACPR had expired several months ago and a new form could not be found at the time of our visit.

Recommendation 3:
The senior charge nurse and service manager should review the DNACPR audit process to ensure that DNACPR forms are reviewed within the identified review period.

People's physical health in Ward 2 was managed by the resident doctors with a 'duty doctor' being available out of hours. We could see that there were clear care plans and risk assessments in people's records about their physical health. There was also an annual physical health check for people in the ward and the multidisciplinary team supported people to undertake health screening wherever possible.

We met with one person who had specific communication needs. We could see from the person's care plan that an interpreter attended the ward regularly and had supported the person to see an advocate and make appeals to the mental health tribunal. We also heard that the person had had regular contact with a peer support worker, who was retiring and that the person's family were exploring alternative communication supports for their relative.

In our review of care records, we saw and heard from the senior charge nurse that a number of people had an identified discharge plan and that options were being explored for others, as appropriate to their stage of recovery.

We reviewed the care records for one person who had been in hospital for many years and heard about a lack of progress with regards to discharge despite a number

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

of potential options having been identified. We have sought further information and will follow up progress for this person with their health and social care team.

Multidisciplinary team (MDT)
We heard from the senior charge nurse and service manager that the multidisciplinary team in Ward 2 was fully recruited to and included nursing, occupational therapy, pharmacy, physiotherapy and psychiatry.

We heard about a patient activity co-ordinator (PAC) who worked five days per week in Ward 2, and how much they were valued by people admitted there and by staff.

There was a multidisciplinary ward meeting held every two weeks. We saw regular recording of MDT meetings in the electronic care records. In most cases, this included information about who attended the meeting, whether the person and their family wished to attend and the views of the person and their family.

We heard that input from other professionals, such as psychology and dietetics, was available following referral to those services.

For people who were temporarily placed in Ward 2 from other services we could see that there were regular meetings with the person's psychiatrist and the nursing team. These meetings happened out with the Ward 2 MDT meeting. The records from these meetings did not always have the same detail as for people in Ward 2. We brought this to the attention of the senior charge nurse at the time of our visit.

In addition to the MDT meetings there were review meetings which happened at least every three months to which the person, their family and carers and social work and other colleagues are invited.

Use of mental health and incapacity legislation

On the day of the visit, nine people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

All documents relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (AWI Act), including certificates around capacity to consent to treatment, were available in the ward in either electronic or paper form and reviewed.

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 kept in a paper file in the ward office. We found that these were in place where required and corresponded to the medication being prescribed. We also saw that there were helpful alerts on the electronic prescribing system for each person who had such certificates in place.

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 copies of the relevant paperwork in the electronic care record.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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 nine section 47 certificates and associated treatment plans for people in the ward and found them to be up to date and containing relevant information about the person's physical and mental health.

We also reviewed AWI Act documentation in relation to power of attorney and welfare guardianship certification. We were able to review all the certification in paper form, including documentation in relation to applications under the AWI Act. We could see that there were alerts on the EMIS electronic care plan to ensure that staff were aware when people had a welfare proxy. In most cases the documentation was available and correct. In one case, it was unclear whether a family member had completed their AWI Act application as intended. We spoke to the senior charge nurse at the time of our visit, and he intended to clarify the stage of the application and update the records accordingly.

We reviewed financial care plans and documentation for people who had been assessed as lacking financial capacity and found these to be appropriately completed.

We heard that people can be referred to advocacy services for support and saw information about these services in the ward. We heard that advocacy tended to focus on mental health and tribunal work.

Rights and restrictions

Ward 2 is accessible through a locked front door with a doorbell entry system. There were sign in and out sheets for all people coming in and out of the ward. People could also leave the ward from the garden area, which had gates leading to other parts of the hospital grounds.

Some people in the ward had been assessed as needing support to go outside or to access the community. Where this was the case, we saw relevant risk assessments and care plans in relation to time out with the ward. We could also see that these care plans were regularly reviewed at the ward meetings.

Three people in the ward were subject to 'continuous interventions'. This means when people have one or more members of staff with them at specific times of the day, due to concerns about risk to themselves or others. We heard from the senior charge nurse that a person-centred approach was taken and that the interventions were regularly reviewed to ensure that they were the least restrictive intervention that could be provided. We could see in people's care records that continuous interventions were being used to ensure people's physical health, for example, for people who were frail and at risk of falling. We saw an example of continuous intervention being used over a short period of time to support someone with their medication at a time when they had had a decline in their mental health. We also saw that continuous interventions could be in place at specific times of day or for specific activities depending on the needs of each person.

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 specified in this way 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 made a recommendation about the need for staff training on advance statements at the time of our previous visit. We heard from the senor charge nurse that this had happened. When we reviewed care records we found one advance statement. We also saw that advance statements were discussed with people and their wishes recorded in their care records. In some cases, people were not able to be involved in discussions about advance statements due to their mental ill health and if so, this was recorded in the person's care records.

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

Ward 2 had an identified patient activity nurse who worked five days per week, including weekends. We heard how much the activities that were provided were valued by people, staff and families and carers.

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

The patient activity nurse also ran a weekly community group with people in the ward to talk about their experience of being in the ward, the things that they wished to achieve and changes that they thought were required. We saw a noticeboard in the ward with feedback and suggestions from people in the ward. This included information about upcoming events.

One relative told us that the ward offered “loads of activities”. They thought that their relative had enough to do and said that they also valued periods of quiet time. They spoke about the person having regained some of the physical fitness that they had had before they became unwell. They told us their relative enjoying cycling again, going to local parks and also taking part in gardening activities.

The weekly timetable for activities was available on the ward’s activity noticeboard and included walking football, visits to local parks and cafes, arts and crafts activities and projects, in house activities such as bingo, movie nights and pamper sessions, and a coffee club.

People in Ward 2 could also access activities in the recreational therapy service and we saw people going out for activities there at the time of our visit.

In addition to the patient activity nurse timetable, ward staff undertake activities such as going out for walks and going out to the shops.

We saw that all activity was recorded in people’s daily progress notes in their care plans and included in the multi-disciplinary team meeting minutes. We saw that consideration was given as to how to support people to take part in activities when they had difficulty doing this by themselves due to mental ill health.

During our visit we saw people using the activities room in the ward which was a large room with a pool table, a range of games and craft equipment, a large television and a smart screen (which was a tablet in the size of a large television screen).

Ward 2 also had a therapy kitchen which was used by occupational therapy for one-to-one work on activities of daily living as well as for therapeutic groups such as smoothie and snack making.

The physical environment

Ward 2 was an H-shaped unit with the ward entrance, therapy kitchen and ward office along one end and the single bedroom spaces at the opposite end.

The ward had wide corridors and a lot of natural light. It was clean and in good repair.

Along the corridor, which joined the office space to the single bedroom space, were the activity room, dining room and servery, day room and two dormitories.

The activity room was in use during our visit. It contained a range of games and craft equipment and art on the walls completed by people. There were tables for people to sit together. There was a large television and a large smart screen for people to use.

The dining room was a large room with an adjacent servery. There were small tables and chairs to allow people to eat in small groups or by themselves. We were told by the senior charge nurse that mealtimes were staggered to allow people to eat at quieter times and also so that people who needed support to eat could have this.

The day room was a large room which had rows of chairs in a cinema style facing a television mounted on the wall. The room felt unwelcoming, and the rows of seating did not allow for people to sit in small groups and engage with each other.

We also saw the treatment room which was a good size and contained an examination couch to allow for physical examination.

We saw noticeboards and information leaflets throughout the ward with a range of information about activities, local resources, ward activities, activities elsewhere in the hospital and local advocacy services. There were pictures on the walls of people in the ward engaging in activities in the ward and in the community. There were also large bright canvases with photographs of landscapes to brighten the ward.

The garden was accessible from the corridor next to the main ward office. There was a pleasant garden space around the corner from the rear ward entrance with large planter boxes which were filled with flowering plants and areas where people could sit together.

We heard from the senior charge nurse and service manager that there had been some disruption to people in Ward 2 due to the proximity of the adjacent mental health assessment unit and the emergency vehicles that could attend at any time of the day. This could be distressing to people. We also heard that people waiting to be seen in the mental health assessment unit could use the Ward 2 garden area. A gate had been put in place to prevent this and ensure people's privacy. We spoke with the senior charge nurse about options such as privacy film on bedroom windows.

There are two dormitory spaces in Ward 2, each with communal toilet and shower facilities, in addition to accessible toilets and bath facilities elsewhere in the ward.

There were separate male and female dormitories. The female dormitory space had four people living in it at the time of our visit, and the male dormitory space had five. The dormitory spaces were clean and tidy but appeared very clinical and people had very few of their own possessions. We saw that one person in the male dormitory had only an area the size of his bed, wardrobe and a table to live in and this was squeezed in between the living space of two other people. We did not feel that this

was adequate given the length of time that people can be in the ward and discussed this with the senior charge nurse at the time of our visit.

We heard from one family member that their relative lived a quiet and private life at home and that being in a dormitory space without privacy was difficult for them. We were told that this person had a number of possessions in their home that they clearly prized and looked after and we discussed that being able to have important possessions in the ward would be comforting to them.

We heard from the senior charge nurse that there was another bedroom space that could be adapted to make another single room to allow the number of people in the dormitories to be limited to four. We heard that it would also be helpful to adapt the single bedroom to meet the needs of people in Ward 2 who had significant physical ill health or palliative care needs. Our view is that the number of people living in each dormitory area should be limited to four people, to allow people to have their own personal space.

Recommendation 4:
The service manager should review the occupancy of the dormitory areas in Ward 2 to ensure that people have sufficient space and privacy..

Recommendation 5:
The senior charge nurse and multidisciplinary team should work with people and families in Ward 2 to consider how the ward can be more homely and support people to have more of their personal possessions and decorations in their bedrooms should they wish.

Smoking
Leverndale Hospital is a non-smoking hospital site under The Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022. At the time of our visit, we could see that people were smoking outside the ward at the entrance to the garden area. We could see cigarette butts around, and on, the bin at the garden entrance, although the communal garden itself was not affected. We met with several people who were regular smokers who had significant mental and physical ill health and who were subject to mental health or incapacity legislation.

We heard that people with impaired mobility were supported to go and smoke at the rear of the ward. We heard that when people could not leave the ward to purchase cigarettes that Ward 2 staff and the people's families did this for them. We were told by senior staff that people in Ward 2 could purchase cigarettes as part of their spending plans, when these were in place due to financial incapacity. We were also told by family members that staff could be seen smoking elsewhere on the hospital site; we will raise this issue with the service manager.

We spoke with senior staff at the time of visit and requested a copy of the hospital's non-smoking site policy. We asked what guidance senior managers had been provided for staff and heard that there was a lack of direction for staff as to how to manage this issue.

Recommendation 6:
Senior managers should review local policy in relation to The Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022 and ensure that clinical teams are provided with clear guidance as to their responsibilities in ensuring that the service is compliant with this legislation, that the clinical team supports the physical health of people in Ward 2 and is in keeping with the principles of mental health and incapacity legislation.

Summary of recommendations

Recommendation 1:
The service manager and senior charge nurse should review the person-centred care plans to ensure that the care plans are up to date, consistently completed, with clear goals to be achieved over a set period of time, and with a focus on the individual.

Recommendation 2:
Senior managers should review the care plan audit tool to ensure that it is effective in supporting good practice in person centred care planning.

Recommendation 3:
The senior charge nurse and service manager should review the DNACPR audit process to ensure that DNACPR forms are reviewed within the identified review period.

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The service manager should review the occupancy of the dormitory areas in Ward 2 to ensure that people have sufficient space and privacy.

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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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