Mental Welfare Commission for Scotland

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

Date of visit: 03 September 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

Balloch Ward is a 16-bedded unit that provides rehabilitation for people as part of a wider rehabilitation service at Leverndale Hospital. It also provides 'contingency' care and treatment for people when general adult psychiatry wards are full. We heard that wherever possible the care and treatment needs of people admitted into contingency beds are matched with the skills of the rehabilitation team.

On the day of our visit, there were 16 people In Balloch Ward and no vacant beds. Eight people were under the care of the rehabilitation service and eight people continued to have their care and treatment provided by the general adult psychiatry teams as contingency care.

We last visited this service in March 2017 on an unannounced visit and made 12 recommendations. Some of these were in relation to care planning, documentation, the involvement of people, and their access to therapeutic activity. Others were in relation to repairs and maintenance of the unit. We received a response to the recommendations in 2019.

For this visit to the service, we wanted to hear from people about their experiences of the care and treatment that is currently being provided, although we were mindful of the previous findings and recommendations.

Who we met with

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

We spoke with the senior charge nurse, a charge nurse, the lead occupational therapist and the discharge co-ordinator.

Commission visitors

Dr Sheena Jones, consultant psychiatrist

Dr Rachael Lee, specialist registrar

Gemma Maguire, social work officer

What people told us and what we found

People told us many positive things about the service. They said, “it is a great hospital”, that they “get on excellent with staff here” and that the staff “are lovely”.

During our visit we saw nursing staff interacting with people with care and compassion and the people that we spoke to said that the staff were kind and caring. We could see that nursing staff knew the people in the ward well and were able to provide us with a lot of information about each person.

We heard from one person how they were supported to have regular contact with their teenage child in a quiet area of the ward and from another about how they had regular visits with their family.

One relative that we spoke to said that they had “not had much contact with doctors” and that there are “things I’ve wanted to know” and “don’t know who to contact.” They spoke about being worried about their relative’s discharge and their benefits. They also said that the nursing staff “always updated them when they were in”. They said that the “staff are great” and “all are helpful”.

Two other people spoke about being worried about their money. One person had not had a functioning bank card in three months. Another person didn’t know what was happening with their benefits. We spoke to the senior charge nurse in relation to the specific concerns and they provided assurance that these issues would be addressed, if they had not already been attended to.

People told us different things about the food that is provided. One person said that they wanted to have more access to tea and coffee, which is currently provided on a trolley in the lounge area at various times of the day. One person told us that they liked the “biscuits and cakes” that are provided with the tea trolley. One person said they “don’t like the food”. People spoke about there being little variety and few vegetarian options. A number of people spoke about the portions being small and that popular meal choices would often run out. The ward team advised that they would share this feedback with the catering department.

Another person told us that they weren’t able to cook what might like in the therapy kitchen; this could give them more choice than what is currently on the menu and could meet their dietary needs in relation to a specific health condition. We spoke to the lead occupational therapist and were told that this person had specific risks in relation to choking and that a multidisciplinary assessment was ongoing to ensure that this risk was appropriately managed.

Care, treatment, support, and participation

We reviewed people's electronic care records on the EMIS system.

Care records

A standard person-centred care plan (PCCP) had been introduced across mental health services in Glasgow and had been in use in Balloch Ward for several months. It had standard sections covering physical health, mental and psychological health, substance and alcohol use, social needs, legislation, and legal aspects of care and spiritual needs.

We reviewed the PCCPs on EMIS and saw that they were in place and contained a range of information about people's mental health, physical health, and medication.

We could see that the PCCPs were regularly reviewed, and new information was added at the time of the reviews. However, this was not consistent and, in some cases, important information about an individual was missing or out of date. This included a change in legal status for one person, and for another it was in relation to their progress towards discharge and time spent at home as part of the discharge process.

We also saw some care plans that had had new information added, but this was recorded in the review section without the main section of the care plan being updated.

While there were standard sections in the PCCP, we found the care plans that we reviewed focussed on mental and physical health. We did not see wider multidisciplinary rehabilitation goals included and in general, the care plans were in relation to nursing care.

The people that we spoke to said that they had "not seen a care plan" or been involved in their development. The care plans that we reviewed did include the views of some people, as recorded following discussion with nursing staff, but there was very little evidence that the person's own goals for treatment and recovery were included.

Some of the people that we spoke to said they did not know what needed to happen for them to be able to go home. The PCCPs did not include specific goals that a person may have to achieve in relation to their discharge. We were told by one of the nursing team that there had been a real change in approach to people in Balloch Ward, with a move away from people continuing to live in hospital to people progressing to community services or active rehabilitation services, depending on each person's specific needs. Whilst we heard about people moving on from Balloch Ward and could see that this was happening, we could not find the evidence of this in people's care plans.

Most of the care plans we reviewed did not show any involvement of the person's families and carers. There was little evidence that they had been involved in creating the care plans or that the care plans had been discussed with them.

Recommendation 1:
The senior charge nurse and service manager should audit the person-centred care plans to ensure that they are accurate, cover all aspects of a person's care and treatment and involve people and their families and carers wherever possible. This should include how people's care plans are shared with them in an accessible format.

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 heard from the senior charge nurse about significant nursing staff absences and the impact that this had had on the named nurse role and the completion of care plans.

In addition to the care plans, we reviewed the Clinical Risk Assessment Framework for Teams (CRAFT) documentation held on EMIS. This is the standard risk assessment and management tool used in the service. We saw CRAFT documents in all case records and evidence that these were regularly updated. They contained information about the person's mental health and relevant historical information. We saw evidence of reactive strategies that may be used when a person was distressed and agitated (including the use of safe holds, increased observation levels and emergency sedation) but there was little information about proactive strategies and risk management approaches that may be helpful to prevent a person becoming distressed or help with de-escalation.

In one case, the risk management strategy was to continue to assess and review risk. For another person who had had a psychological formulation completed, we did not see that this was considered in the risk management plan.

Recommendation 2:
The senior charge nurse and service manager should review and audit the CRAFT risk assessment and management documentation to ensure that it adequately reflects people's multidisciplinary care and treatment.

Multidisciplinary team (MDT)
In addition to the senior charge nurse (Band 7), there are three charge nurses (Band 6), seven staff nurses (Band 5) and 11 healthcare support workers. At present there are only two Band 5 staff nurses at work (which amounts to a 1.5 whole time

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

equivalent). The Band 5 staff nurses act as the named nurse for each person in the ward. We heard that the charge nurses and senior charge nurse have had to try and cover these absences, in addition to completing their own duties.

We heard from the senior charge nurse that two new staff nurses had been appointed to the service who will take up post in the coming months.

We heard from senior staff that there has been difficulty in recruiting to the consultant psychiatrist post in Balloch Ward for several years. There has been a locum consultant in post for six months each year (over the winter months) who knows the service well. For the remainder of the year there have been different consultant psychiatrists covering the service which has meant that there have been three different consultant psychiatrists for rehabilitation patients over the last six months.

A number of people told us that they struggled with the number of different doctors they had seen. One person said it is “hard because the doctors keep changing” and another said that they had had “eight different doctors”.

We heard from the senior charge nurse that the ward doctors look after the physical health of people in Balloch Ward. This includes an annual health check, physical investigations, therapeutic drug monitoring, and monitoring of any high dose medication.

We heard that there is pharmacy input to the service and that this will also support the ward doctors to ensure people’s health in relation to their medications.

We spoke with the lead occupational therapist after our visit, as we were not able to meet with them on the day. We heard that they had worked with all 16 people in Balloch Ward at various times and that they were currently actively involved with ten people. There had been a number of people who had been re-referred to the occupational therapy (OT) service and three people had had a recently updated functional OT assessment. We heard that people have one-to-one assessment and treatment during which they can work on things like meal planning, budgeting, shopping and cooking in the therapy kitchen. We heard that approximately eight people in Balloch Ward were working one-to-one with the OT team at the time of our visit.

The OT team provided activity-based groups in Balloch Ward (such as breakfast and lunch groups) with people being able to choose which activities they wish to do, support with transition and discharge and who worked alongside the discharge co-ordinator. We also heard that people in Balloch Ward can access any of the OT groups occurring across the hospital site.

With care planning, we heard that the OT team use their own treatment plan for each person. There is a weekly activity schedule for Balloch Ward, but people will also have their own individualised weekly timetable.

In addition to nursing and OT staff, there is also a health care support worker who functions as a patient activity nurse. They work eight-hour shifts, across the seven days of the week and provide in-house activities such as walking groups and support for people to undertake activities in the community. There is also physiotherapy and dietetics provision in the ward.

Psychology services can be accessed on referral, and we saw evidence that one person had had a recent psychology assessment and formulation completed. This provided an improved understanding of the person's sensory needs and the resulting environmental changes have led to a significant reduction in the person's level of agitation and aggression, to the point that discharge planning could be considered.

Psychology services can also provide behavioural family therapy (BFT) groups when there is an assessed need. This was not currently required in Balloch Ward.

We spoke with the discharge co-ordinator on the day of our visit. We heard that they attend the MDT meetings in the acute general psychiatry wards. They can arrange time-focussed additional support for people from a community support organisation and will link with social work teams and the community mental health teams to support discharge planning. They also meet on a weekly basis with social work senior managers to discuss people who are considered to be delayed discharges (which is when a person is ready to leave hospital but there is no identified community option) to consider housing needs and the commissioning of services.

We reviewed the minutes from the multidisciplinary team (MDT) meetings in each person's electronic care records on EMIS. The minutes gave an update as to the person's progress and the intended actions in relation to their care and treatment.

For people in the rehabilitation service, we saw that there was generally good recording of who was present at the meetings, with people's care and treatment discussed on a fortnightly basis. The minutes recorded whether the person had chosen to attend and their views if they had attended. It was less evident if people's families and carers were invited to the MDT meetings, and we saw only one discharge planning meeting where a relative had been present.

For people who were receiving their care and treatment on a contingency basis, there was far less information recorded in the minutes of the meeting. In most cases only the consultant psychiatrist and a member of nursing staff were present. We heard from nursing and MDT staff that there was no set MDT meeting time for people who were not in the rehabilitation service and that this made it difficult for other people to be present.

We also heard that for a small group of people that there would be a single general adult consultant identified to provide better consistency and communication. We look forward to hearing of the progress with this.

Recommendation 3:
The service manager should review multidisciplinary meeting processes for people in Balloch Ward to ensure that they support the involvement of people, their families and carers and members of the multidisciplinary team.

Use of mental health and incapacity legislation

On the day of the visit, ten people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was accessible in the person's electronic care record and was up to date and correct.

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 available on the electronic care record, in addition to paper copies in a folder in the treatment room. This allows nursing staff to ensure that they can review documentation when medication is being dispensed.

The consent to treatment forms and certificates were in place where required and corresponded to the medication being prescribed.

For two people who were receiving informal care and treatment we found that as-required intramuscular medication was being prescribed for emergency sedation. We contacted the relevant consultant psychiatrist in each case. In neither case had this medication been used. These medications have now been discontinued.

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. We did not review any named person documentation.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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 those people that were being treated under the AWI Act, we found section 47 certificates in the electronic care records, and associated treatment plans with information about the person's physical and mental health care.

Information about people's financial capacity was held in a separate paper folder in the ward and this included information about individual's budgeting and spending plans.

We could not always find information in people's care records about their decision-making capacity, for people who were not subject to any legal powers. We discussed with the senior charge nurse that where staff have any concerns into areas of individual decision making and capacity (welfare or financial), that these should be discussed and recorded in the MDT minutes to evidence consideration, assessment and review.

Recommendation 4:
The senior charge nurse and service manager should audit care records to ensure that there is a clear documentation about each person's ability to make decisions in relation to their welfare and finances.

We shared our AWI learning resources with the senior charge nurse after our visit and look forward to seeing progress in relation to how capacity is considered and recorded in a person's care plan when we next visit.

Rights and restrictions

Balloch Ward has a locked front door and a buzzer entry system to ensure general ward safety, however, people in Balloch Ward can come and go through the unlocked garden entrance to the rear of the ward. We heard from staff that people will let the nursing team know when they are leaving the ward and when they will return.

We reviewed care records for people who had "continuous intervention" (CI) care plans; CI means when people have constant support from a member of staff to ensure their safety. Four people in the ward had continuous interventions in place at mealtimes due to an assessed risk of choking. Two people were supported for short periods of time due to need for support with taking medication as prescribed. The rationale for the use of continuous intervention was clearly recorded, took the least restrictive approach and was centred on the person's care and treatment needs.

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 and where restrictions are introduced, it is important that the principle of least restriction is applied.

Where specified person restrictions were in place under the Mental Health Act, we found that the relevant paperwork was present in the care records and correct.

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 saw that there was regular recording in the ward MDT minutes about discussions with people about Advance Statements, however, people had chosen not to complete these.

We spoke to people about being able to access advocacy services. One person told us that their advocate was "wonderful". Other people told us about their past or current support from advocacy in relation to their mental health act status, mental health tribunals and their concerns about their care and treatment. One person told us that they didn't fully understand what an advocate would do and wanted to see an advocate. We could see that they had had contact with advocacy services in the past. We spoke to nursing staff on the day of our visit to request that the person be re-referred to advocacy. We also spoke with senior staff after the meeting about the possibility that advocacy could provide a drop-in service, as they do in other units, and this will be considered.

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

When we spoke to people about their activities some people told us that they had "plenty to do here in the ward" whilst others said that there was "not enough to do here at nighttime", that "Sundays are boring". One person told us that nursing staff will take them out, but "only if they are not busy".

Balloch Ward has a patient activity nurse who provides a range of scheduled activities in the ward. There is a timetable of activities in the activities room and people spoke about how they valued these.

People in Balloch Ward can also access the Recreational Therapy service and we heard about the wide range of activities that are on offer there and how much people value attending.

Some of the activities we heard about included playing pickleball, a swimming group, yoga and relaxation and artwork activities.

We heard that there is a community group in the ward led by one of the staff nurses which is well attended and gives people the opportunity to discuss their care and treatment in the ward. We also heard that recently, there had been a focus on

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

smoking cessation at the community group, to support the non-smoking hospital site work.

The local mental health network also provides a regular “Patient Conversations” group and we saw information about what had been discussed at recent meetings on the white boards in the ward dining room.

There is a carers group held once a fortnight in Leverndale Hospital which all family members and carers can attend.

The physical environment

Balloch Ward is bright and clean with wide corridors and lots of natural light. It was in good repair.

The ward is accessed via a locked front door with a corridor that opens into the dining room and servery spaces, which have vending machines with drinks and snacks. This area is also used as a visiting space, as it is quiet and separate from the main ward area.

On entering the ward there is a central lounge area “the day room” with adjacent activities room. The day room has a large television and comfortable seating areas. It is decorated with pictures and paintings and has large windows overlooking the garden. There were games and craft activities available in the day room and more resources, including a therapy kitchen in the adjacent activities room. The timetable of activities available in the ward was displayed on the door to the activities room.

The garden area is accessed through an unlocked door in the day room. The recent work to update and maintain the garden area was evident and there was new garden furniture and a large pop-up shelter outside. We could also see the planters that had been made and that had been planted up with the help of a local volunteer group.

While efforts had been made to refresh and maintain the garden area it was evident from the cigarette butts in the gravel alongside the garden paths that people continued to smoke in the garden area.

Someone who was a non- smoker spoke about people smoking outside in the garden and that they did not like the smoke coming into the ward. They felt that it affected their breathing. We also heard from another that the ward was “not as clean and tidy as it should be.”. They said that people smoked outside the ward and that cigarette ends can end up on the ward floor as people walk in and out.

We heard from the senior charge nurse about recent and ongoing work within the service in relation to smoke free hospital legislation. People were supported to access smoking cessation services and nicotine replacement therapy. There had been information-sharing and education at the community group to inform people

about the no smoking legislation. We heard that one long term smoker had successfully stopped smoking following this work. We look forward to seeing progress that is made towards a smoke free environment at our next visit.

The nursing office is adjacent to the day room and there are patient toilets and a quiet room in the corridor next to this. There were information boards in this corridor about activities, advocacy, community café and group activities. We also saw local artwork throughout the ward, including work completed by people in the ward while at the recreational therapy service.

People slept in dormitory spaces that had been adapted so that everyone had a single room. Most of the rooms were en-suite and there were showers and toilets in the dormitories for those who did not have an en-suite bedroom. In the female dormitory areas, the layout had allowed for the creation of small lounge areas, and the ward iPad was set up in one of these for a person who used it regularly.

There were additional shower and bathrooms in the main corridor. We heard that the bath was used by some people but was currently not in use while a replacement part was awaited.

Laundry facilities were also available in the main corridor, and some people used these independently.

There was a reasonably-sized treatment room in which medication was stored. It had a laptop so that nursing staff could access the electronic medication system, 'HEPMA'.

People in the ward were able to keep their food in a small pantry. People's food was labelled and the room is kept locked. This ensured that individual's specific needs in relation to boiling water and choking were safely managed. We heard that the ward also provides a regular tea trolley throughout the day so that people can access hot drinks and snacks.

Summary of recommendations

Recommendation 1:
The senior charge nurse and service manager should audit the person-centred care plans to ensure that they are accurate, cover all aspects of a person's care and treatment and involve people and their families and carers wherever possible. This should include how people's care plans are shared with them in an accessible format.

Recommendation 2:
The senior charge nurse and service manager should review and audit the CRAFT risk assessment and management documentation to ensure that it adequately reflects people's multidisciplinary care and treatment.

Recommendation 3:
The service manager should review multidisciplinary meeting processes for all people in Balloch Ward to ensure that they support the involvement of people, their families and carers and members of the multi-disciplinary team.

Recommendation 4:
The senior charge nurse and service manager should audit care records to ensure that there is a clear documentation about each person's ability to make decisions in relation to their welfare and finances.

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