Mental Welfare Commission for Scotland

Report on announced visit to:
Leverndale Hospital, IPCU, 510 Crookston Rd, Glasgow, G53 7TU

Date of visit: 23 March 2026

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The intensive psychiatric care unit (IPCU) at Leverndale Hospital is a 12-bedded unit for individuals aged 18-65 years who require intensive treatment and intervention. Individuals are generally from the South Glasgow area. The function, layout of the ward, and facilities were unchanged since our previous visit.

On the day of our visit there were two vacant beds.

The ward is a mixed-sex facility, split to accommodate a maximum of three females in single rooms, with nine to 12 male beds provided by a mix of single rooms and small dormitories. At the time of this visit, there were eight men and two women in the IPCU.

We last visited in December 2024 as an announced visit and made three recommendations. These included the need to review how live care plans were kept up-to-date, that reasoned opinions were completed, and that work was progressed to ensure the IPCU was fit for purpose.

The response we received from the service was that managers had ensured audits were in place for care plans and medical staff had ensured that reasoned opinions were completed. We heard that managers had undertaken a feasibility study with capital planning and architects to apply for funding to upgrade the IPCU environment.

On the day of this announced visit, we wanted to meet with as many individuals and their families on the ward as possible, to hear about their experience and their views of the care and treatment provided to them by the service.

Who we met with

We met with nine individuals and reviewed their care notes. We also met with one relative.

We spoke with the service manager, the operational nurse manager, the senior charge nurse, the deputy charge nurses, the consultant psychiatrist, the specialty doctor, the psychologist, the lead occupational therapy, the lead physiotherapist, the therapeutic activity nurse, and nursing staff throughout the day.

Commission visitors

Justin McNicholl, social work officer

Karen Beattie, nursing officer

Alison Thomson, nursing officer

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included the reason for their admission, their legal status, contact with staff, individual participation in their care and treatment, activities that were available to them and their views about the environment. We were also keen to hear from individuals who had been in the ward for over three months and from those who had been subject to restrictive measures.

We received a variety of feedback on the care received. Most people's feedback was positive about the staff. They described staff as "helpful", "caring" "alright" and "approachable". One individual told us, "I enjoy it here, the staff look after me, they treat me well, it's like a 5-star hotel". Another stated, "I've been to other wards in the hospital and this is the best, the staff and the ward is calmer". Similar to our last visit there were positive comments from individuals on the psychiatry staff, who were reported to be "easy to access" while one individual spoke of "knowing where you stand" when it comes to treatment options on offer.

We met with one distressed individual who was not happy with their treatment and was complaining about the options that were available to them. We discussed how to address this issue with advocacy services, with their doctor and the nursing staff. We met one individual whose first language was not English. They advised us of the steps taken by staff to overcome any communication barriers, by using digital technology and interpreters.

Most individuals were clear on the role of the multidisciplinary team (MDT) meetings which occurred weekly. Individuals spoke of being able to obtain updates on any changes or plans for their care, as required throughout the week, from a variety of staff.

During our time on the ward, we saw staff interacting and communicating with individuals in a positive and supportive manner. Individuals who we noted to be acutely distressed by symptoms of mental ill health received a compassionate and measured response from staff. Staff that we spoke with knew the people in the ward extremely well. Conversations with staff were positive and nursing staff described being well supported by senior staff; they were receiving clinical supervision, with the opportunity to reflect on practice being actively promoted.

We spoke to one relative who highlighted that there could be some improvements to the male and female ratio of staff on the ward. From their point of view, this was to ensure that the cultural and personal preferences of individuals were being met. This was particularly important when continuous interventions or restrictive measures were used for female patients who did not feel comfortable working with male

members of staff. We agreed to pass on these comments to the staff for their consideration.

Similar to our last visit, we received several negative comments about the ward environment. This included, “this place is a dump” and “it is not fit for purpose”.

Individuals pointed out that there were holes in the walls of the corridors which we too observed. We were concerned to hear about issues with the female toilets. We visited these and found them to lack privacy, which compromised individuals’ dignity. This was due in part to the fact the cubicle doors had been removed. The cubicle panels next to the toilets were found to be damaged, which meant that if individuals were subject to continuous interventions they would have to be observed and in reaching distance. We were advised by staff of the ligature risks that the toilets pose to the patient group.

It was our findings that the toilets appeared to pose a direct risk to the health and safety risk of individuals and staff members on the ward. Managers spoke of steps that were planned to improve these conditions.

Recommendation 1:
Managers need to ensure that repairs and improvements are made to the ward toilets to protect individuals’ safety, privacy and dignity.

The Commission remains very concern that the previous recommendations to make the ward fit for purpose have yet to achieved by the health board since our last visit. This is despite the fact we have been provided with repeated assurance that changes to the environment would be addressed as a priority.

We heard from the health board clinical management team of the various options in place to address the poor facilities, with the hope that a decision will be made this year on whether to proceed with significant funding improvements. If approved; this work will require a decant of individuals to achieve the renovations. We look forward to hearing when these improvements will be authorised and processed as a high priority.

On this occasion we received positive comments about the food on offer with individuals describing it as “good”, “excellent” and “lovely”. We observed the food on offer at lunch time; we noted good portion sizes with various cultural and ethnic preferences being tailored for by the service.

We found the ward currently benefits from good leadership and has developed clear processes that has enabled a consistent and structured nursing process; this is especially important in an environment that cares for the most acutely unwell individuals. The mix of individuals, with a variety of extremely complex needs can

make an IPCU a challenging place to work, but we found a calm and therapeutic environment that aimed to support recovery.

Care, treatment, support, and participation

Care plans

Care plans are a tool that identify detailed treatments and interventions that are to be delivered; effective care plans can ensure consistency and continuity of care and treatment. Care plans should be regularly reviewed to provide a record of progress being made.

During this visit we found improvements in the recording of care plans and how they were reviewed. We found these to be detailed, with clear evidence of them being person-centred, reviewed regularly and linked to MDT meetings. We found they focused on recovery, with specific, individualised goals.

Some individuals we met with had no understanding of their care plans; this appeared to be due to their mental illness. Those who were well enough spoke of their limited awareness of their care plans. Where individuals disagreed with their care and treatment, their views were recorded in the MDT or in the daily notes.

All care plans were accessible on the electronic recording system, EMIS.

Care records

The service has a well-established electronic patient records system, EMIS used by NHS Greater Glasgow and Clyde (NHS GGC). The EMIS system record for each person contained their detention paperwork, care plans, risk assessments, physical health monitoring, admission paperwork, contact details and information on their GP as well as their nearest relative, if consent had been given by the patient.

We found most records on the electronic and the paper systems to be up to date. The information was easily accessible and provided a holistic picture of individual care needs and progress. The care records addressed the risks identified in the CRAFT risk assessments, which were regularly updated. Where physical health needs had been identified, these were addressed.

Multidisciplinary team (MDT)

Similar to our last visit, there was a broad range of staff providing input to the IPCU. The ward has one consultant psychiatrist, one doctor with a specific remit for the ward and one junior doctor.

The MDT notes included input from psychology, pharmacy, occupational therapy and the activity co-ordinator. For individuals who required additional support from allied health professionals, referrals were made to specific services including physiotherapy, speech and language therapy, and dietetics.

Each member of the MDT provided care and treatment specific to their expertise and where required, provided weekly feedback at the meeting. We found MDT meeting notes were detailed, with clear progress or future plans noted. All MDTs included action points noting who was responsible for taking the specific matter forward.

We found clear and consistent plans in place by the ward staff to ensure participation and engagement with families and in maintaining regular contact. We heard there was input from social workers or mental health officers to the service. Managers advised us that due to the ongoing demands placed on hospital beds across NHS GGC, the ward continues to discharge individuals directly from the IPCU. The staff spoke of the ongoing therapeutic rehabilitation in place to address these demands.

We met with the leads for occupational therapy and physiotherapy for the ward; they both spoke of their hopes to increase their workforce to meet the demands of the service across the hospital site. They told us of the increase of individuals presenting with dual diagnoses of mental illnesses and neurodiversity and how they were working with psychology staff to be better equipped to address the needs of those with these clinical presentations.

Use of mental health and incapacity legislation

On the day of our visit, all nine of the individuals in the IPCU were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All individuals that we met with during our visit had a good understanding of their detained status.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. We examined the hospital electronic prescribing and medicines administration (HePMA) system that was in place across NHS GGC, which assists nursing staff with the administration of all medication. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the prescribed medication.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this in the care record. We found copies of social circumstances reports (SCRs) on EMIS which helped staff understand individuals' backgrounds in a comprehensive manner.

Rights and restrictions

The IPCU continues to operate a locked door policy commensurate with the level of vulnerability and risk of the patient group. There were individual risk assessments in

place that detailed arrangements for time off the ward and the support required to facilitate this safely.

We were pleased to hear from staff that in keeping with previous visits in 2023 and 2024, that there has been a significant decrease in the use of the de-escalation room and incidences of violence.

Individuals could use the garden area of the ward if they so wished, to ensure they had time out with the ward environment and the opportunity for exercise.

We heard from individuals about their access to advocacy services and we heard that there were no barriers to this important safeguard.

We observed individuals who were subject to continuous interventions, which mainly took place in the area around the individuals' bedrooms. We found these were being delivered to a suitable standard, were reviewed on a regular basis with consideration of removing these restrictions as soon as possible. The individuals that we met with understood the rationale for this level of restriction.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are subject to detention in hospital. Where an individual is a specified person in relation to these sections of the Mental Health Act and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised, and that the need for specific restrictions is regularly reviewed.

On the day of our visit, there was one individual who was subject to these procedures, and we were told that these arrangements were being reviewed that day and would likely cease.

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. On the day of the visit, we found no advance statements had been made.

Activity and occupation

Activity and meaningful occupation, particularly in an IPCU, is important due to the level of restrictions individuals face.

Similar to our last visit we heard about the importance of occupational therapy staff and access to the recreational therapy (RT) department on the Leverndale site. This input was well regarded by those that we spoke with.

People we met that were confined to the ward had access to activities which included pool, television, newspaper groups, and the opportunity to listen to music. We observed activities undertaken by health care support workers and the appointed therapeutic activity nurse (TAN).

The TAN role has ensured that there is an opportunity to offer activities to all individuals on a one-to-one basis or in small groups. During our visit we were able to observe a full list of daily activities that were displayed on the wall of the dining room.

We heard from several individuals that despite the hard work of the TAN there were limited items available to occupy their time. We heard that there was only one television, iPad and Nintendo switch for 12 patients. Individuals spoke of their frustrations at the lack of devices, which resulted in them having to wait for these items becoming available to aid their mental health. For those significantly restricted for long periods of time they felt this was causing harm and distress. Managers advised of their intentions to purchase replacement iPads as the previous devices had broken and with upgrades to the ward additional items may become available.

Recommendation 2:
Managers should address the lack of suitable technological equipment to provide consistent stimulation to individuals in the ward.

The physical environment

The physical environment of the ward remains largely unchanged since our last visit. The ward continues to be stark, with little personalisation in place and there were signs of general wear and tear throughout all areas of the ward.

Similar to our previous visits, the decor of the ward did not provide a positive experience for individuals and the use of dormitories made privacy and promoting a good sleep pattern problematic. We noted that there were no call alarms available for individuals in any of the bedroom or dormitories

The lack of en-suite facilities for all individuals continued to be raised by those that we spoke with. We noted that those subject to contentious interventions were generally confined to their bedrooms, with no toilet or showering facilities available in these rooms. Individuals were required to be supervised to move to a separate room to shower or use the toilet.

The aging facilities remain far from ideal for maximising patient care. We heard that these poor conditions were having a direct impact on female patients having to use damaged toilet facilities which are not fit for purpose. Staff reported that female patients could not use the same toilet facilities at the same time due to safety concerns surrounding the conditions.

We noted that some of the bedroom doors were damaged and required replacing due to incidents of aggression. We found holes in the walls of the main corridors.

The large meeting room which is used for the MDTs was found to be very cold on the day of the visit, as was the senior charge nurses office. These uncomfortable conditions continue to highlight how unfit for purpose the facilities are for both individuals and staff members.

The Barron Report: Independent Forensic Mental Health Review : final report was commissioned by the Scottish Government and published in 2021. This report was particularly critical of the current dormitory style IPCUs in Scotland. The report made specific recommendations regarding the physical environment of services where forensic patients may require care and treatment and for health boards to address these issues. These recommendations remain relevant for the IPCU.

We heard from managers of the ongoing capital bids made to undertake significant improvements to the ward which have yet to be approved; it has been a number of years since the Commission first raised these concerns.

Recommendation 3:
Managers should work urgently to ensure that the IPCU environment is safe, welcoming, therapeutic and fit for purpose.

Summary of recommendations

Recommendation 1:
Managers to ensure that repairs and improvements are made to the ward toilets to protect individuals' safety, privacy and dignity.

Recommendation 2:
Managers should address the lack of suitable technological equipment to provide consistent stimulation to individuals in the ward.

Recommendation 3:
Managers should work urgently to ensure that the IPCU environment is safe, welcoming, therapeutic and fit for purpose.

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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