

Mental Welfare Commission for Scotland

Report on announced visit to:

Leverndale Hospital, Balmore and Banff wards, Crookston Road,
Glasgow, G53 7TU

Date of visit: 28 April 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

Baltimore Ward is an 18-bedded ward which provides care for older people with an organic mental illness. The ward is divided into two self-contained single sex units, one with eight beds and the other which has 10 beds.

Banff Ward is a 20-bedded, mixed-sex ward with six single rooms and three dormitories. The unit provides assessment and treatment for older adults who have a functional mental illness.

Together, Baltimore and Banff Wards provide the older adult mental health admission facilities for south Glasgow.

On the day of our visit, there were no vacant beds, and Baltimore Ward had several individuals boarded out into wards across the city.

We last visited this service in February 2025 as an announced visit and made no recommendations.

Who we met with

We met with and reviewed the care of 12 people, six who we met with in person and six who we reviewed the care notes of. We also met with four relatives.

We spoke with the service manager, the senior charge nurses and members of the nursing team.

In addition, we met with the occupational therapists and the physiotherapist.

Commission visitors

Mary Hattie, nursing officer

Karen Beattie, nursing officer

Laura Young, nursing officer

Mary Leroy, nursing officer

Adebola Adegbite, medical officer

What people told us and what we found

Everyone we spoke to was very positive about their experience of the ward and of the ward staff. We heard that “the nurses are fantastic, so kind, and not just the nurses. The domestic staff are amazing, they would go to the end of the earth for the patients”. We were told by a relative that “everyone is so welcoming and I can go home and rest with an easy mind, knowing they are cared for and staff will contact me if there are any issues.”

We did hear that while some bank staff were compassionate, there were a number who spent time on their phones and did not respond to individuals who needed assistance. This was raised with the manager at the end of day meeting, and we were told that this was an issue that was being addressed and bank staff were given a copy of the unit rules which all staff were expected to abide by.

The physiotherapist and occupational therapists told us about work which had been undertaken in liaising with care homes. This had enabled them to safely and appropriately reuse available specialist seating to meet the needs of individuals who were ready for discharge. This pragmatic approach avoided delays when waiting for funding and delivery of new seating, thus allowing for a quicker discharge.

Care, treatment, support, and participation

Care records

Information on patients’ care and treatment is held in the main on the electronic record system EMIS, and the electronic medication management system, HEPMA.

Care plans, nursing assessments, multidisciplinary team (MDT) reviews, and chronological notes were held on EMIS, along with Mental Health Act paperwork. Paperwork relating to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) was kept in the paper file.

In the care records we reviewed, we found meaningful and relevant chronological notes. One-to-one sessions with staff were recorded and ‘Getting to Know Me’ (GTKM) documentation was in place in the records we reviewed. GTKM is a summary of information about the individual’s life and preferences which helps staff understand the person’s needs and ensures that the care that is delivered is person-centred.

The wards have been without psychology input for some months, resulting in them being unable to complete full Newcastle formulations. However, staff have ensured that individuals who present with stress and distress have person-centred care plans which focused on minimising the triggers for their distress and detailed the interventions which reassured, supported and de-escalated the distress the individual was experiencing.

The ward has continued to develop their 'five things that matter' cards, designed to provide readily accessible information to assist staff. This, alongside 'What matters to Me' and GTKM provided a comprehensive framework for the delivery of person-centred care.

In both wards, CRAFT risk assessments were completed and reviewed regularly and in the associated care plans we reviewed, these were person-centred, although in Balmore Ward, the level of detail provided in these varied. We found one individual who was on enhanced interventions, where the nature of the risk had not been reflected in sufficient detail in the risk assessment and the associated care plan.

The Commission has published a [good practice guide on care plans¹](#). 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.

Recommendation 1:

Managers should audit care plans and risk assessments to ensure these contain sufficient detail to reflect and support the high standard of person-centred care being delivered.

Multidisciplinary team (MDT)

The wards are served by three consultants, each covering a geographical area, and they have dedicated input from a therapeutic activity nurse, occupational therapists and physiotherapists. There is regular input from pharmacy and other allied health professions, and specialist services are available on a referral basis.

We found the MDT meeting notes were detailed, and they included clear decisions, along with any actions that were required and who was responsible for completion of these. Individuals, and their relatives/carers were invited to attend MDT meetings. If relatives are unable to attend meetings, staff contacted them to provide feedback.

The psychology post had been vacant for six months. This has now been recruited to and the new staff member will commence in September, providing slightly more than a half-time input (0.6 of a whole time equivalent) across the wards.

As a result of this vacancy and two charge nurse vacancies in Balmore Ward, the decision was made to pause participation in Healthcare Improvement Scotland's (HIS) quality improvement project on stress and distress. The charge nurse vacancies have now been filled, and the ward will relaunch this project in June, with a focus on more intensive face to face meetings with families shortly after admission, to offer support and improve the quality of information gathered in relation to the individual's presentation and previous life.

¹ *Person-centred care plans good practice guide*: <https://www.mwscot.org.uk/node/1203>

Following recommendations from a significant adverse event review (SAER), Balmore Ward has been reviewing their skill mix and is working to reduce the number of occasions where Band 5 nurses are the sole registered nurse on a shift.

Across the two wards, there were 13 individuals who had been identified as having their discharge from hospital delayed. These were being managed through regular review at the MDT meetings and through the integrated discharge team. We heard that this has not worked as well as anticipated.

There have been difficulties with staffing that has resulted in community-based social workers being allocated cases. Social workers had not been attending MDT meetings and as a result, assessments were not being compiled in a multidisciplinary way and did not reflect the individuals' current presentation.

This has impacted negatively on the ability to find care home placements and has contributed to the number of delayed discharges. There have been recent discussions with the integrated care team and managers to try to resolve this issue, resulting in it now being mandatory for allocated social workers to attend MDT meetings on a regular basis to improve the quality of assessments.

There has also been a change to complex care bed provision, which is now at Dykebar Hospital. This has led to a waiting list for these beds resulting in delays in moving patients on to a more suitable placement for them.

Use of mental health and incapacity legislation

On the day of the visit, 25 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) across the two wards. All documentation relating to the Mental Health Act was in place.

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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

Where an individual had granted a Power of Attorney (POA) or was subject to a guardianship order, details of powers granted, and the contact details of the proxy should be held on file. We found this information had been recorded and copies of powers were on file for the individuals we reviewed.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate 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. In Balmore Ward we found that several

section 47 certificates had not had the section completed indicating that the proxy decision maker had been consulted.

Recommendation 2:

Managers should audit section 47 certificates to ensure that these record consultation with proxy decision makers.

For those individuals who had covert medication in place, all appropriate documentation was in order.

Rights and restrictions

Both wards continue to operate restricted entry, commensurate with the level of risk identified in the patient group. There was information on how to enter and exit the ward available near the doors in both wards. We saw staff responding promptly and greeting relatives on arrival. Both wards offer open, personalised visiting arrangements.

The reception area of Balmore Ward had information boards and stands, providing helpful information, signposting local carers' services and a wide range of relevant health information leaflets. There was also a prominently displayed suggestion box, with paper and pens available and a 'you said, we did' board, showing actions taken because of individual and carers suggestions. Information on advocacy was clearly displayed.

Banff Ward had a notice board providing information on advocacy, chaplaincy services, carers' support groups and other resources available and providing information about the ward and the activities which were being provided.

Section 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 individuals designated as specified person under the Mental Health Act 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 did not find any statements on file but were told that advance statements were discussed with individuals prior to discharge.

Information packs for patients and carers providing information on legal status have been in use for some time. These have been augmented by a discharge information

leaflet. Work is also ongoing to develop future care planning, ensuring information relevant to an individual's future care is accessible to staff in other settings.

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms were stored on the clinical portal as well as EMIS.

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

The wards have input from a therapeutic activity nurse who provides a comprehensive activity programme; this was supplemented by ad hoc activity provision by the nursing team.

The occupational therapist provided a breakfast and a lunch group once a week in Banff Ward. These groups provided both a social function and helped to assist individuals to maintain their skills.

Individual outings to community facilities were also supported by the occupational therapists. The physiotherapist provides a weekly exercise group in each ward. This was tailored to the needs and abilities of the participants.

We noted that there were activities available throughout the day, including a variety of group and individual activities which people could choose to attend. There were relaxation groups, quizzes, pamper sessions, reminiscence groups, musical activities, crafts and games. There were a number of external activity providers involved, including volunteers who run craft groups, staff from the Music in Hospitals project and other volunteers who provided musical events.

Throughout our visit, staff were observed spending time chatting with people and engaging in one-to-one activities.

Activity participation and outcome was recorded in the chronological notes, and we found that information on both individual activities and small group involvement was recorded.

Activity provision was developed by the information in the GTKM documentation and through the person's choice on the day. Several individuals mentioned the activity co-ordinator and how much they enjoyed participating in the activities.

² *Rights in Mind*: <https://www.mwscot.org.uk/law-and-rights/rights-mind>

The physical environment

In Banff Ward, there was a spacious, bright dining area, shared with the rehabilitation unit next door, as well as a lounge, a large conservatory and a dedicated activity room which was well stocked with games, magazines, books and craft supplies.

There was a therapeutic kitchen, used by those in the ward as well as access to domestic laundry facilities. There was access to a small secure garden area which was used regularly.

Sleeping accommodation was a mixture of six single rooms and three small dormitories. Single rooms had en-suite toilet facilities but did not have shower facilities. Dormitories had ensuite toilet and shower facilities and there was a shower and a bathroom off the main corridor. Staff told us that there could be pressure caused by the need for the use of the shower room in the morning.

In Balmore Ward, the female unit comprised of several small dormitories and two single bedrooms; all the bed areas have en-suite toilet facilities. The male unit comprised of one small dormitory and six single rooms. Each unit has a pleasant sitting and dining area.

The female unit was considerably larger and benefitted from a dining area that was separated from the sitting room; this was beneficial when activities were taking place or for accommodating visitors. The male area, while bright and well lit, was smaller and would have benefitted from having a quiet area away from the main sitting dining area.

While these were two discrete areas which were separated by a door that was operated by a swipe card, this door could be opened for periods during the day to enable people to move between the two areas if it was felt to be safe and beneficial to people at the time. The corridors were wide, bright and clean.

The shared garden area was dementia-friendly. We were told that the garden area was popular with those in the ward and with visitors alike. We noted that several of the en-suite bedrooms had anti-ligature doors in place. We heard that despite stronger magnets being provided since our last visit, they remained a potential falls risk as people attempted to steady themselves on the doors and they were designed to be easily dislodged. This also meant that an individual's dignity and privacy could be compromised. We were pleased to hear that an alternative solution is being considered with a different door design having been installed in an acute ward on site, with a view to this being rolled out across the hospital. We look forward to seeing this in place on our next visit.

We heard that Balmore Ward had been experiencing delays in response to requests for repairs to furniture and fixtures, such as replacing dislodged curtain rails.

Recommendation 3:

Managers should ensure that requests for repairs are addressed promptly to maintain an environment which is safe and dignified.

We noted that there was evidence of smoking in the gardens in Banff Ward, with cigarette ends evident on the ground. We heard from staff that every attempt is made to implement the smoking policy, but it is difficult to enforce this. Individuals are reminded of the policy on a regular basis, nicotine replacement is available and smoking cessation support is offered by the specialist nurse on a weekly basis.

We previously made a recommendation about the environment in Banff Ward not being fit for purpose and have commented on the limited space in Balmore Ward. We are aware that the review of older adult mental health inpatient services is progressing. We are hopeful that this may address these issues and we look forward to receiving the recommendations from this on its conclusion.

Summary of recommendations

Recommendation 1:

Managers should audit care plans and risk assessments to ensure these contain sufficient detail to reflect and support the high standard of person-centred care being delivered.

Recommendation 2:

Managers should audit section 47 certificates to ensure that these record consultation with proxy decision makers.

Recommendation 3:

Managers should ensure that requests for repairs are addressed promptly to maintain an environment which is safe and dignified.

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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