

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Leverndale Hospital, Wards 3A, 4A and 4B, 510 Crookston Road, Glasgow, G53 7TU

Date of visit: 28 July 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

Ward 3A, Ward 4A and Ward 4B are acute admission services providing mental health care and treatment for adults aged 18 to 65 years.

Each ward has 24 beds. Wards 4A and 4B comprise single ensuite bedrooms, while Ward 3A has a mixture of dormitory accommodation and two single bedrooms, with access to shared bathroom facilities.

Ward 4B also provides the Esteem Service, a specialist mental health service for individuals aged 16 to 35 years who appear to be experiencing a first episode of psychosis.

The services cover geographical areas across Glasgow (Castlemilk, Govan, Ibrox, Pollok and Crookston), East Renfrewshire (Barrhead and Eastwood), and South Lanarkshire (Cambuslang and Rutherglen).

On the day of our visit, there were 24 individuals in both Ward 4A and Ward 4B. Ward 3A had 23 individuals admitted, and one vacant bed.

We last visited the service in March 2025 as part of two unannounced visits. At that time, we made recommendations relating to person-centred care planning and medication administration. We also made recommendations regarding the application of legal safeguards, including welfare guardianship under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) and specified person provisions under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). There were recommendations made regarding compliance with smoke-free hospital legislation. We made specific recommendations relating to the décor in Ward 3A and the recording of multidisciplinary team (MDT) meetings in Wards 4A and 4B.

The service advised that audit processes, staff supervision and training were being strengthened to improve person-centred care planning, MDT documentation, medication authorisation and the application of legal safeguards. We were also informed that health and safety improvement plans were being implemented across the service.

Since our last visit, the Commission has followed up on incidents that were subject to multi-agency investigation and wider organisational learning. During this visit, we wanted to focus on the actions taken by the service to address issues identified through these investigations, including the implementation of policies and procedures relating to risk documentation, physical healthcare of individuals, and communication with families and unpaid carers.

Who we met with

Ward 3A

We met with two people during our visit. We reviewed the care notes of one of these individuals and also reviewed the care records of a further five people.

Ward 4A

We met with seven people during our visit. We reviewed the care notes of three of these individuals and additionally reviewed the care records of one other person.

Ward 4B

We met with eight people during our visit. We reviewed the care notes of four of these individuals and additionally reviewed the care notes of one other person

We met with one relative on the day of our visit.

We spoke with a range of staff, including senior charge nurses (SCNs), charge nurses (CNs), an occupational therapist (OT), a physiotherapist, the project manager for suicide and self-harm reduction, and the service manager (SM).

Commission visitors

Gemma Maguire, social work officer

Mary Hattie, nursing officer

Denise McLellan, nursing officer

Anne Craig, social work officer

Tracey Ferguson, social work officer

Laura Young, nursing officer

What people told us and what we found

Many of the individuals we met with on Wards 4A and Ward 4B described the service as “good” and “excellent”. We heard that staff were “thoughtful”, “helpful” and “friendly”. One relative told us that staff were supportive and that communication with them was clear.

In contrast, some of the people we met with on Ward 3A told us that, although staff were caring and supportive, the ward felt “understaffed” and “chaotic”. During our visit, we observed a noticeable difference in the level of distress being experienced by individuals on Ward 3A compared with those on Wards 4A and 4B.

There were also notable differences in the facilities available on Ward 3A, including the use of shared dormitories. We heard that some individuals found sharing a dormitory difficult and, at times, felt it was “unsafe”, particularly when people were feeling overwhelmed or distressed. Individuals also told us that there was limited private space in the ward where they could go to “decompress” and spend time away from others.

We were concerned to hear from both individuals and staff on Ward 3A about hygiene issues and access to essential personal care items, including toilet roll.

These matters were discussed with SM on the day of our visit. We were advised that Ward 3A had been decanted to an adjacent ward to allow essential health and safety works to be carried out. However, managers were clear this should not affect standards of cleanliness or access to personal care items.

Several of the people we met with were accessing advocacy services or seeking legal advice. Some individuals who were not subject to the Mental Health Act told us they had not received information about advocacy services, although they felt access to this information would be helpful.

We discussed this with the SCNs during our visit. We were advised that contact details for local advocacy services are available on each ward and can also be obtained from staff. We were assured that all individuals would be provided with information about advocacy services and that support would be offered to help them make contact, where required.

We were pleased to find that the physical health needs of the individuals we met with were being appropriately monitored. We heard how consistent involvement from OT and physiotherapy services has contributed to a holistic MDT approach for individuals with complex physical and mental health needs.

While we found some improvements in the recording of person-centred care plans, risk assessments and MDT documentation, this was not consistent in all of the records we reviewed. We discussed these issues with the service during our visit and

were advised that audits of person-centred care plans had identified variation in the quality of documentation between staff members. We were informed that practice development leads were supporting staff to improve recording practices and promote greater consistency.

Care, treatment, support, and participation

Care records

All care records, including care plans, multidisciplinary team (MDT) records and risk documentation were accessible through the electronic recording system, EMIS.

We reviewed several care plans that identified key themes relating to individuals' physical and mental health needs, as well as discharge planning. We found some detailed care plans that included interventions to support individuals with complex mental and physical health needs.

We were pleased to find that care plans included the views of individuals, as well as views of families and unpaid carers in Ward 3A and Ward 4B. Some plans in Ward 4A had not recorded the views of individuals or their families, despite evidence elsewhere in the clinical record that consultation was taking place on a regular basis.

We found person-centred language was being used in several care plans we reviewed, including quotes using the person's own words, however this was not consistent.

While most care plans were reviewed regularly, this was not the case across all the records we examined. For example, one person we met with was progressing in their discharge from hospital and spending overnight passes at home although their care plan had not been updated to reflect this key information.

We found evidence of nursing and medical interventions which related to identified care plan themes, such as pharmacological treatment for psychotic symptoms. There was a lack of sufficient detail regarding wider recovery-focused goals, such as engagement in therapeutic or leisure-based activities to reduce isolation and strengthen social skills.

The Commission has previously made recommendations regarding person-centred care planning in these wards and across other NHS Greater Glasgow and Clyde (NHSGGC) mental health services. In response, we have been advised that actions have been implemented to improve practice, including the introduction of regular audit processes, a new person-centred care planning template and associated guidance.

Despite these actions, we were disappointed to find examples of inconsistent practice. This includes instances where individuals' views were not recorded, and where care needs and progress towards agreed goals had not been documented.

We also continued to hear from staff during our visits that the documentation can be difficult to use. The Commission also found the care planning template challenging to navigate. The template is a word document in which individual themes and care needs are recorded at the beginning, while review sections are located separately at the end of the document. For individuals who have been admitted to hospital for an extended period, the document can become lengthy, requiring staff to scroll through multiple pages to locate information or record updates. This structure can make care plans more difficult to review and maintain, particularly where staff are managing competing clinical demands.

Recommendation 1:

Managers should review the current audit processes for person-centred care planning to ensure they consistently identify areas for improvement and support the development of good practice. Auditing arrangements should provide assurance that individuals' views, care needs, goals, and progress are recorded consistently and to an appropriate standard.

Recommendation 2:

Managers should review person-centred care planning documentation to ensure it is accessible, easy to navigate, and supports effective recording and review of care. The revised format should enable staff to readily record and access individuals' views, care needs, goals, and progress throughout their admission.

NHS Greater Glasgow & Clyde (NHSGGC) use the Clinical Risk Assessment Framework for Teams (CRAFT) to record, assess, and manage individual risk. The Commission has made recommendations relating to risk documentation, particularly risk management information, following a number of visits to NHS GGC mental health services. We have raised concerns through our investigative work following significant incidents where risk documentation and/or risk management information was missing. We have also shared this information with Healthcare Improvement Scotland to assist with their inspection duties in relation to NHSGGC mental health inpatient services.

In response, NHSGGC has advised the Commission that the CRAFT policy, training materials, and associated guidance have been updated. These updates include clearer information on when risk assessments should be completed or reviewed and emphasise the importance of maintaining up-to-date risk management plans. We have also been advised that regular audit processes are in place to identify issues and support practice development.

During our visit to Ward 3A, Ward 4A and Ward 4B, CRAFT documentation was present in all the care records we reviewed.

However, we were disappointed to find that information on how individuals should be supported to manage identified risks was not always clear. In some records, details of risk management strategies were limited or absent, making it difficult to determine the actions required to support individuals safely and consistently.

Similar to the concerns outlined in relation to person-centred care planning, we continued to hear from staff during our visit that the CRAFT document can be lengthy and difficult to use. We also found that risk recording focused on dates and descriptions of historical incidents. While this provides useful context and a chronology of risk events, it was not always easy to identify an individual's current risks and the actions required to manage those risks effectively.

During our visit, we reviewed a sample audit of care records that included CRAFT documentation. While the audit had confirmed that CRAFT assessments had been completed and reviewed within the required timescales, it had not identified instances where not all relevant risks had been recorded or where risk management plans lacked sufficient detail. As a result, the audit did not fully reflect the quality of risk assessment and risk management documentation in the records we reviewed.

Recommendation 3:

Managers should review current auditing processes for CRAFT documentation to ensure they consistently identify and address deficiencies in risk assessment and risk management recording, and support ongoing practice development.

Recommendation 4:

Managers should review the design and layout of the CRAFT documentation to ensure it is user-friendly and supports effective assessment, recording, and management of current risks, including clear and accessible risk management plans.

Multidisciplinary team (MDT)

The MDT meetings continue to be held weekly and consist of nursing staff, consultant psychiatrists, junior doctors, pharmacy, OT, physiotherapy and psychology.

We were pleased to find detailed psychology notes in individual care records. Several people we met were able to provide a good understanding of the therapeutic work being undertaken during their psychology sessions.

We also found that individuals were regularly reviewed by pharmacy staff. These reviews supported treatment planning and helped to identify and manage any side effects associated with some prescribed medication.

We found the template used across the service to record MDT meetings to be clear and intuitive. Records provided a detailed account of discussions that had taken place and included clearly documented actions arising from the meetings.

On our previous visit to Ward 4A and Ward 4B, we found inconsistencies in the recording of attendance at MDT meetings. During this visit, we continued to find similar issues in both wards. In Ward 3A we found no issues in relation to recording attendance at MDT meetings.

Recommendation 5:

Managers for Wards 4A and Ward 4B should ensure that MDT records detail everyone in attendance.

Use of mental health and incapacity legislation

On the day of the visit, 40 people across Ward 3A, Ward 4A and Ward 4B were detained under the Mental Health Act. All individuals detained under the Mental Health Act were aware of their rights. A number of the individuals whose care we reviewed had nominated a named person, were receiving legal advice and accessing advocacy services.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be provided to individuals who are detained and are either capable or incapable of consenting to specific treatments. The Commission has made previous recommendations in relation appropriate authority being placed to provide treatment to individuals under the Mental Health Act. In response, we had been advised that regular audits were carried out in relation prescribed medication and with the authority to administer treatment.

We found that consent to treatment certificates (T2) were in place and corresponded with the medication prescribed in all three wards.

In Ward 4B, we identified no issues in relation to certificates authorising treatment (T3). However, we identified one error in Ward 3A and three errors in Ward 4A where prescribed medication was not included on individuals' certificates authorising treatment (T3). Although nursing staff had completed an audit of treatment authorisation certificates, these discrepancies had not been identified.

We identified one individual in Ward 3A who had been prescribed intramuscular (IM) medication on an "as required" basis despite not being subject to the Mental Health Act. The Commission has concerns about the prescribing of IM medication in these circumstances, as there is no legal authority to administer it without valid consent.

Any advance agreement to receive IM medication would become invalid if the individual withdrew consent at the time of administration or if restraint was required. Where an unforeseen situation arises in which IM medication may be required, the Commission's view is that services should have protocols in place to ensure that consideration is given to detention under the Mental Health Act and that appropriate legal safeguards are applied.

We discussed this issue with the charge nurse, who agreed to contact the consultant psychiatrist to ensure that the prescription was reviewed and the IM medication was removed.

Recommendation 6:

Managers should ensure there are clear arrangements in place to prevent the prescribing of "as required" IM medication where there is no legal authority for its administration.

Recommendation 7:

Nursing and medical staff should ensure that all prescribed medication is appropriately authorised under the Mental Health Act, and that regular audits of treatment authorisation certificates are sufficiently robust to identify any discrepancies.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; they are called a named person. Where an individual had nominated a named person, we found documentation to be accessible and the named person had been appropriately consulted.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

For one individual we met with on Ward 3A who had a section 47 certificate in place, we did not see a treatment plan, which is called an Annex 5. The treatment plan should be written to include all the healthcare interventions that may be required during the time specified in the certificate. The treatment plan should be clear on whether the individual has capacity to make decisions regarding nutrition, hygiene, skin care, vaccinations, eyesight, hearing, and oral hygiene.

Recommendation 8:

Medical staff should ensure that where a treatment plan is required, it is completed for individuals, in line with the code of practice for medical practitioners.

Rights and restrictions

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 an individual is made a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit, two individuals were subject to specified person measures under the Mental Health Act: one person in Ward 3A and one person in Ward 4A.

We reviewed the care records for both individuals and found that the appropriate paperwork had not been completed for the individual in Ward 3A in relation to restrictions on telephone use (RES3).

We also found that neither individual had been provided with written information about the restrictions imposed on them, including information on review timescales and their rights. We discussed these issues with the SCNs and SM during the visit. We were advised that training and guidance on specified person procedures had been issued to staff and that the concerns identified would be escalated to the responsible consultant psychiatrist for action.

Recommendation 9:

Managers should ensure that appropriate paperwork is completed for all restrictions applied to individuals who are subject to specified person measures under the Mental Health Act.

Recommendation 10:

When an individual is made a specified person, managers should ensure they are provided with written information about the restrictions imposed, the timescales for review, and their rights.

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. Where individuals had an advance statement in place, the electronic system provided an alert to ensure staff reviewing the person's record were aware. We found some evidence that advance statements were being discussed in MDT meetings, but this was not consistent. In discussion with SCNs, we were advised that nursing staff and advocacy services support individuals to complete an advance statement whenever appropriate to do so.

Some individuals we met with had been admitted on an informal basis and were unaware that they could leave the ward and hospital grounds if they chose to do so. One individual was subject to continuous intervention, with staff providing enhanced observation and support to manage the risk of harm.

We reviewed the care records for some individual's who were admitted informally and found no evidence that they had consented to restrictive interventions, or had been given information about their rights, or that this had been discussed with them during their admission. We raised our concerns with the SCN and SM on the day of our visit and advised the service that individuals should be informed of their rights, with discussions regarding consent clearly recorded and regularly reviewed.

We also advised that the use of rights-based care plans would help ensure that consent, legal safeguards, and individuals' rights are actively considered throughout admission, while supporting the provision of appropriate rights-based information.

Recommendation 11:

Managers should ensure that all individuals are informed of their rights and that consent to any restrictive interventions is clearly recorded and regularly reviewed.

The Commission has developed [*Rights in Mind*](#).¹ This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

Group and individual activities continue to be provided through the on-site recreational therapy centre, patient activity coordinators (PACs), occupational therapy (OT) and physiotherapy services. People in Ward 4A and Ward 4B told us how important the PACs and OT services were to their recovery.

We heard that many individuals were learning, developing and maintaining daily living skills in preparation for discharge. Activities by the service included functional assessments, community transition groups that support recovery and discharge planning, as well as regular breakfast and lunch clubs. Individuals could also choose from a range of ward-based activities, including walking groups, art groups, and regular one-to-one time with the PAC, nursing and OT staff.

We were pleased to find that engagement in activity programmes was being recorded and evaluated in care records.

Across all three wards, we heard that high levels of clinical activity, alongside staffing and resource pressures, can, at times, affect the ability of the wards to consistently provide ward-based activities.

We met with some individuals in Ward 3A who expressed the view that PAC input could be improved and made more flexible to better reflect individual preferences. We heard that activity provision is generally available between 11am and 4pm and that sessions can sometimes feel "chaotic", with activities being determined by the PAC rather than through individual choice. We discussed this issue with SM on the day of our visit and were assured the feedback will be taken into consideration by the service.

On the day of our visit, the activity room in Ward 3A was being used for a storage area and was not able to be used for individuals. We were advised this was a temporary measure to safely prepare for the wards move back its original location,

¹ *Rights in Mind*: <https://www.mwscot.org.uk/law-and-rights/rights-mind>

following completion of health and safety work. We were assured that individuals would have access to an activity room following the move.

The physical environment

Some of the people we met with in Ward 3A told us about difficulties accessing essential personal care items and access to appropriate facilities for the disposal of feminine hygiene products. We also observed that the floor in one bedroom was heavily stained.

In addition, we heard from some individuals that the ward environment can appear "dirty" at times; some individuals were considering pursuing complaints regarding these issues. We heard that these concerns had been evident for several weeks and that, despite escalation by staff, inconsistencies in the quality and provision of domestic services in Ward 3A had continued. Some staff we met with told us they frequently undertake domestic tasks to address gaps in service provision, however this can be difficult to sustain alongside the clinical demands of care.

We discussed these concerns with the SM and the project manager during our visit. They advised us that Ward 3A had been temporarily decanted to an adjacent ward to allow essential health and safety works to be undertaken.

We were also advised that ward store cupboards contain an adequate supply of essential items, including toilet roll, are accessible to both domestic and ward staff. In addition, we were told that feminine hygiene waste disposal units are available on the ward and that arrangements are in place for their regular cleaning and servicing.

We made further enquiries with managers responsible for Ward 3A following our visit and received assurance that the issues relating to personal care items and domestic services had been investigated and fully resolved.

During our visit we were provided with a tour of the completed work health and safety work in Ward 3A and were pleased to note that improvements had been made to the ward environment and décor since our last visit.

While all three wards provide an acute adult admission service, there are notable differences between the ward environments. For example, Ward 3A includes shared bedrooms and bathroom facilities, whereas Ward 4A and Ward 4B have single ensuite bedrooms. Some people in Ward 3A told us about the lack of privacy when sharing with others. We also heard that the shared bathrooms in Ward 3A have showers which operate using timed sensors, providing only a limited period for showering and that they can be slow to activate. We heard that, in contrast, the bathroom facilities in Wards 4A and 4B can be operated directly by individuals without difficulty, and no concerns were raised about these arrangements.

Recommendation 12:

Managers responsible for Ward 3A should ensure that concerns raised in relation to the provision of domestic services are dealt with as a matter of urgency, and individuals have access to essential personal care items.

Recommendation 13:

Managers should consider the replacement or adaptation of the shower sensor system in Ward 3A. This could improve the experience for individuals and help ensure greater consistency with the facilities available in Ward 4A and Ward 4B.

At the time of our last visit to the service, we made recommendations in relation to compliance with legislation regarding hospitals being smoke free. During this visit several individuals we met with were receiving nicotine replacement therapy which was being encouraged by staff. Despite this, we were disappointed to find that some people were using garden and/or entrance areas to smoke.

The Commission is clear that smoking on hospital grounds is an offence, with individuals being at risk of penalty notices and fines. While the Commission understands that individuals may experience difficulties in relation to nicotine withdrawal, we are aware that other acute adult admission services are effectively managing smoking bans and utilising nicotine replacement and support services. We would encourage NHSGGC managers to ensure staff have clear guidance regarding implementation of the smoking ban. The Commission continue to escalate these concerns with NHSGGC managers.

Recommendation 14:

Managers must ensure compliance with the [Smoking, Health and Social Care \(Scotland\) Act 2005 \(part 1\)](#) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

Summary of recommendations

Recommendation 1:

Managers should review the current auditing processes for person-centred care planning to ensure they consistently identify areas for improvement and support the development of good practice. Auditing arrangements should provide assurance that individuals' views, care needs, goals, and progress are recorded consistently and to an appropriate standard.

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Managers should ensure that appropriate paperwork is completed for all restrictions applied to individuals who are subject to specified person measures under the Mental Health Act.

Recommendation 10:

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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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