Healthcare Improvement Scotland

mental welfare commission for scotland

Report on the joint unannounced visit/safe delivery of care inspection

Skye House

NHS Greater Glasgow and Clyde
August 2025

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Foreword

The Minister for Social Care, Mental Wellbeing and Sport committed to address the serious concerns raised by the BBC documentary (aired in February 2025) regarding the experiences of young people in Skye House in Glasgow. The Minister commissioned the Mental Welfare Commission for Scotland (the Commission) and Healthcare Improvement Scotland to carry out visits/inspections across all three young people units in Scotland and the separate children's in-patient psychiatric unit in Glasgow.

As part of this collaborative approach, Healthcare Improvement Scotland and the Commission committed to ensure that our skills, experience and resources were jointly used to deliver comprehensive, independent and robust assurance of the units.

In August 2025 we visited/inspected Skye House. Skye House is a 24-bedded Tier 4 specialist Child and Adolescent Mental Health Inpatient Unit based in the Stobhill Campus Glasgow. Child and Adolescent Mental Health Tier 4 services are highly specialised units, for young people who require assessment and treatment for complex mental health needs. Skye House has three wings, Mull, Harris and Lewis and cares for young people who may have a range of mental health conditions such as depression, psychosis and eating disorders. Skye House is the regional unit for the West of Scotland. Young people may occasionally be admitted from other regions if there are no other available beds.

About this visit/inspection

We undertook a joint unannounced visit/inspection to Skye House in August 2025. Two different methodologies were employed and are described in Appendix A.

Whilst the Commission and Healthcare Improvement Scotland's approaches are different, they are also complementary. The context of systems, leadership and governance (the macro level) scrutinised by Healthcare Improvement Scotland has a direct relationship to the experience of those receiving care and treatment (the micro level and statutory focus of the Commission) and vice versa. The aim of this collaboration therefore was to jointly deliver enhanced, independent assurance of the unit.

The Commission and Healthcare Improvement Scotland would like to thank NHS Greater Glasgow and Clyde, all staff in Skye House, the young people receiving care and treatment in Skye House, their families, advocacy staff and mental health officers for engaging in this joint unannounced visit/inspection process.

Experience of care and treatment

What the Commission did

While the Commission's usual approach involves visiting a ward on one day, on this occasion we visited Skye House over a six-day period in August 2025. There were 24 young people receiving care and treatment in the 24 bedded unit throughout our visit.

The length of stay of the young people in Skye House ranged from less than one week to approximately 10 months. 18 young people were receiving care and treatment on a compulsory basis according to the Mental Health (Care and Treatment) (Scotland) Act 2003.

24 health records of the young people were reviewed by Commission staff and double read by a second different Commission mental health professional (that is, each record was reviewed by a nurse and a doctor, by a social worker and a nurse etc.).

We engaged with 22 young people and 15 nursing staff who described themselves as the young people's key workers/named nurses.

We engaged with the relatives/carers of 19 young people.

23 of the multidisciplinary staff working directly on the unit provided us with information.

We also received feedback from 15 mental health officers and one response was received from the advocacy service working with the young people on the ward at the time of our visit.

The Commission was also invited to attend the first carer support group held on the ward on 27 August 2025.

His Majesty's Inspectorate of Education met with the Commission after their education inspection at Skye House.

What we heard

Children and Young People

What we expect:

Inpatient Child and Adolescent Mental Health Services (CAMHS) are regarded as Tier 4, that is, they are required to meet the needs of young people with the most complex, severe or persistent mental health problems[1.]

We would expect young people receiving services in Skye House to receive holistic, person-centred care delivered by an experienced, specialist, multidisciplinary team which is inclusive and recognises the young person as a unique individual. We would expect the young person to have a key worker/named nurse with whom they have built or can build a therapeutic and trusting relationship. We would expect young people to be fully aware of their rights, to be treated with dignity and respect and for all interventions to be lawful.

What we heard:

There were 24 young people on the ward when we visited; 11 of whom had more than one diagnosis. 18 of the young people were receiving care on a compulsory basis (according to the Mental Health (Care and Treatment) (Scotland) Act 2003), whilst six were receiving this voluntarily.

We received feedback from 22 young people aged between 12 and 17 years.

Only 12 young people said that they had been given enough information about the ward/unit. Some caveated this with perhaps being too unwell at the point of admission, others explained that their admission had initially been voluntary and they were not told that they could have left the ward if they wanted to.

And concerningly, another person told us that when they were a voluntary patient, they were told they could not leave and if they tried to leave, they would be detained. They spoke about being confused by this and did not understand what this meant, and *"it felt really unfair"*. This was confirmed in case records where there was no evidence of a discussion about rights-based care and seeking the young person's consent to having their time out of the ward restricted. We noted from case records that another person had asked to leave hospital and was prevented from doing so but still remained a 'voluntary patient'.

Others mentioned being given a booklet but suggested this could be summarised as it was too long to read at the point of admission and more geared to planned admissions.

Most of the young people who engaged with us said that subsequent information provided was explained in a way that was easy to understand, including legal status, advocacy, diagnosis, rights and medication. Support from parents, advocacy staff, Mental Health Officers (MHOs) and the responsible medical officer was said to facilitate this.

One person told us, the other doctor *"did not listen to me and never took the time to meet me. I really like Dr [alternative doctor], he is much better and proactive. I am happy with medication; it is helping me".*

Another young person singled out the information she had been given about medication as being particularly helpful.

Almost all of the young people understood that they had a named nurse or keyworker. Some spoke positively about the 1:1 support but the majority said that contact was not regular due to annual leave or the named nurse working nights. The named nurses told us 1:1 sessions were offered regularly but not all young people felt able to tolerate these discussions.

The 13 young people who told us that they had a plan of what is going to happen to make them well so they can leave the ward/unit spoke positively about this (10 of them said they had been centrally involved in compiling the plan sometimes with their parents' support).

"Yes, I am going to a meeting today to discuss this. I am getting better and hoping to start on home passes this week which will be really good however I do not want to worry or overwhelm myself I want to discuss with the MDT [multidisciplinary team] team and take their advice".

"I have a good, detailed plan for leaving hospital and am already having a lot of passes out with my family".

One person commented, *"More the nurses' goals than mine – they don't include the interventions that would really help me, but my doctor includes me about it".*

18 out of 21 young people who were prescribed medication told us that they understood why they needed it and they were able to tell us about their medicines and rationale for taking them linked to their health conditions.

"My doctor said the medication won't change my thoughts but it might help reduce the strength of them".

"I am aware what the medication is for and feel it is helping me".

Most were clear that they understood the benefits and reasons for medication so would not refuse. They also explained that they were aware that where mental health orders are in place, they could not refuse and may receive intramuscular medication (IM), or it would be re-offered when next due.

"I did refuse it in the past when I was really unwell and was IM'd for my safety and the safety of others. I take it [medication]now as I am better".

Another young person explained that they too had refused medication previously and was then *"given encouragement to take it…nothing else happened after that".*

12 out of 19 young people felt they were fully involved in all aspects of their care and 12

out of 21 young people said that staff talk with them regularly about how they are feeling. Some young people spoke about finding it difficult to speak about their feelings and that *"staff can be too busy".*

"No one talks to you unless you are distressed and need assistance as you have self-harmed or to cut a ligature".

Whilst some said they would not talk to nurses, another said *"nurses are amazing".*

There was a mix of views regarding young people feeling staff listen to what they have to say about their care and treatment.

"This depends on the staff member. Some do; some don't".

"Yes, I feel permanent staff listen to me bank staff do not know me or care about me so I would not discuss anything with them".

"I pick the nurses I like. They take more time and are kinder".

When asked about any restrictions being in place, all young people who responded said that they are able to see their parent or carer when they want to. The key concern related to a blanket ward policy on use of mobile phones.

"I don't agree with the ward policy for phone use which is weekdays 4-5pm, 7-9pm and weekends additional 1:30-3pm".

Another young person said she "hated" the ward policy on phones and said that the main thing she would like to use her phone for would be to watch a movie to alleviate boredom. She said that if she had her phone *"I would feel more normal".*

There was a general view that the blanket policy on phones was *"ridiculous"*, one person said it should be *"tailored to the individual"* whilst one or two other people said they understood why this was necessary. When discussed with named nurses, they reflected on challenges and risks of uploads of videos on social media and the majority agreed with these restrictions stating it was *"ward policy"* to limit phone use.

During our visit we noted a referral from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services. We would have expected to see care plans relating to transition in case records but found none. There was a discharge planning care plan that showed discharge destination and plan for CAMHS to remain involved in care but no detail or evidence of family/carer involvement or information which would have achieved the aim of detailed and documented transition planning. The Scottish Government produced clinical process guidance for young people moving between CAMHS and adult mental health services which were developed in consultation with CAMHS users to further Action 21 of the Mental Health Strategy: 2017-2027[2]. We would expect these processes to be followed for the transition of a young person who has been diagnosed with a serious mental illness, particularly considering the investigation and recommendations from the Commission's Mr D3[3] case.

Case records highlighted that 11 out of the 24 young people at Skye House when we visited had been restrained/secluded and/or given urgent medication against their will.

Five young people said they had care plans in place for when they are finding things difficult and are struggling. Most young people said they didn't. One person reflected on different restraints they had experienced and said none were good experiences, but where staff tried to speak with them, this felt more supportive.

Another person described her experience to Commission staff that during restraint *"1 member of staff holds her head, 1 her legs, 1 her right arm and 1 her left arm and there is a 5th member of staff giving her the NG [nasogastric tube] feed".* She said this led to no injury or bruising.

There was consistent feedback that young people did not think bank staff were trained in restraint and were "rough". A number of young people could not readily recall whether physical health checks were done after restraint (named nurses/key workers confirmed that this was not formal routine practice and often was not required as 'holds' might be light, for example, simply holding a young person's hand for reassurance). One young person told us:

"I have asked staff about this [physical health checks] they said they do not do a formal check but look for bruising etc. which is reasonable, I think".

"I have not been checked after and when I complain of bruising, they say I should not have resisted them which makes me feel really bad again".

Those who engaged with us generally felt they were not discriminated against or treated differently to others. However, unconscious bias was raised as was different treatment related to age and whether this was the person's first admission or not.

Half of the young people said they liked the food on the ward whilst the other half did not. 16 young people mentioned various groups and activities available during weekdays; school, the diamond group, monthly therapet, walking group, art therapy, sports days, cooking club (not happened recently), crafts, board games etc. However, young people were aware that the level of access to the school was determined by which local authority area they resided in. The lack of activities in the evenings and weekends was a key concern leading to boredom. The young people made suggestions about not having such repetitive activities, having staff spend more time with them or take them out of the ward and having an Xbox. However, the consistent theme raised was the lack of staff.

"Too much of the activity is all arts and crafts if you aren't arty there's nothing much to do all day – you just get left with your thoughts".

Nursing staff also suggested that more could be done in relation to activities:

"…many of the activities are younger female focused and don't meet the need of older adolescents and particularly males".

Whilst most young people said it was quiet enough to sleep at nighttime, some

referenced using ear defenders/plugs as sometimes people were unsettled. Nightshift staff were reportedly noisy at times. Whilst most young people reported feeling safe on the ward, others described experiences of assaults by fellow patients, fellow patients placing confidential information online and witnessing distressing behaviours.

"Usually feel safe but it can be scary when someone needs held – staff are really busy then so no-one checks how you are".

None of the young people on the ward had completed an advance statement (despite some having experienced multiple admissions). From discussions with young people and staff and through the review of case records there appeared to be no consideration or discussion of advance statements.

The young people were asked to rate (on a sliding scale) how well they thought they were looked after on the ward/unit overall. Most people said "okay", three people said "really good" and four said "not very good" or "awful".

Carers/Relatives

What we expect:

Section 278 of the Mental Health (Care and Treatment) (Scotland) Act 2003 places a duty on the NHS, and local authorities to take steps to mitigate the impact of detention on family relationships. This duty applies where a child is under 18, is detained or when a parent of a child is detained. This is in keeping with article 23 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and respect for home and family life.

We expect therefore that families should always be allowed and encouraged to offer information to professionals involved in a young person's care and treatment. In all situations, and regardless of the young person's consent or capacity, families can give information to the professionals involved and staff should listen to them. Families and carers know the young person best and can provide valuable information that does not breach the confidentiality of the relationship between the young person and the professional team. The Commission's carers, consent and confidentiality good practice guide[4] explains this in more detail but an inclusive approach to carers, relatives and people important to the young person cannot be understated.

What we heard:

A total of 20 parents/relatives of the young people in the unit engaged with us during our visit to Skye House, this included two parents of one young person.

Their experiences of feeling involved in the young person's care were often determined by who the staff involved were. Names of particular supportive staff were given and were described as *"terrific"* and *"he goes above and beyond what he needs to do".* Whilst most parents/relatives said they had received enough information, this was caveated by many that it was because they themselves had been proactive in seeking out information.

Review of case records suggested that the parents/carers of 23 of the 24 young people were involved in some form in their young person's care planning.

Parents, however, spoke about incidents on the ward that they were not made aware of and only learned directly from their young person when they next visited. We also heard about an early care plan meeting due within 10 days of admission which took 22 days, we heard about no access to a named nurse for one month, meat being given to a young person who was a known vegetarian, formal complaints being made by relatives and discussions had but actions not necessarily being followed through and concerns about making complaints in case that impacted on the young person's care. Some parents were upset that they could not access the ward area and see where their children were sleeping and check their rooms for washing etc. They said the areas they were allowed in were in need of refurbishment.

The majority of relatives/carers said there were not enough things for the young person to do in the ward/unit throughout the week and weekends/evenings. Again, the concern about limited and different levels of access to school was highlighted based on the local authority the person resided in (as raised by the young people we spoke with).

"Getting behind in school will make it all the harder to re integrate".

Restrictions in relation to access to phones also impacted on relationships with some relatives and some of them compared with other inpatient units which they said had far more activities and a much more relaxed policy in relation to phones (the latter not always welcomed by some parents).

"Worry is when no occupation leads to isolation and increased self-harm".

An adult carer support plan had not been discussed with the significant majority of relatives/carers. 17 of them had never heard of this. Some families told us that siblings could be regarded as young carers but again they had never heard of a young person's statement. Information was provided accordingly. Efforts are being made to bring relatives/carers together and focus on their needs and the first Skye House carer support group took place on 27 August 2025 with attendance of four parents for three young people in the ward. Those in attendance were keen to see this meeting continue and evolve.

On a sliding scale of five points from very satisfied to dissatisfied, 14 relatives/parents described being satisfied with the care and treatment provided to their young person with six scoring lower.

Staff working directly on the unit

What we expect:

The 2020 Child and Adolescent Mental Health Services (CAMHS): national service specification[5] explains the Getting It Right for Every Child (GIRFEC) approach and confirms that CAMHS should work on a multiprofessional basis towards shared decision making and formulation. We therefore expected to find a multidisciplinary approach to

the care and treatment of young people in Skye House underpinned by respect for individual roles and contributions and characterised by positive collaboration between professionals.

What we heard:

There is a wide variety of expertise and specialisms who contribute to the care and treatment provided at Skye House. From physical health care nurses to mental health nursing, to medical, to activity coordinator, art psychotherapy, psychology, dietetics, physiotherapy, family therapy, pharmacy and occupational therapy…but no social work. We are grateful to the 23 staff who took time to speak with Commission visitors and/or completed the questionnaire provided.

All staff clearly expressed their genuine job satisfaction and their shared value of the multidisciplinary team where there is mutual respect for different roles and responsibilities.

"I enjoy my role and proud to work in Skye House".

"Working with our young people is such a privilege. I enjoy the challenge of supporting our young people and watching their recovery journey unfold".

There was a shared commitment to ensure that young people were fully aware of their rights, whether detained in hospital or receiving care and treatment on a voluntary basis with advocacy services and MHOs seen as key partners.

Staff reported that they understand the relevant consent and decision-making requirements of legislation. Rather than expect that this rests with medical or nursing staff only, other professions spoke of their confidence in this area too.

Most staff confirmed that they had received child and adult protection training (primarily via LearnPro, an online training/learning system) and all staff reported that they feel confident and competent in their reporting duties in relation to adult/child protection.

All staff reported that they can speak up if they see practice which is not the best it could be however one or two respondents suggested that some practice by staff may be "more about them being on their knees". Nevertheless, we would expect any poor practice to be raised and addressed irrespective.

When we asked if staff felt supported to do their job to the best of their ability, only 16 chose to answer this question with 13 replying positively. Most caveated that whilst support was available the challenge of not having enough staff could not be ignored.

We asked staff whether there were any challenges in relation to managing smoking/vaping as per legislative requirements. Whilst this was not an issue that had come to some staff's attention, others explained that nicotine replacement therapy (NRT) is available and offered. We were told by one member of staff (which reflected what others said) that:

"specialist smoking cessation staff come into Skye House and talk through options for support and NRT...as time has passed and people have gotten used to the smoking ban it has become easier to manage".

When asked what gets in the way of giving the highest quality of care and treatment staff want to give to people, capacity issues/staffing levels across all disciplines impacting on the level of care to young people featured most strongly. There was concern that this led to inequitable access to specialist support, permanent nurses had additional pressure trying to support bank staff and other temporary staff, lengthy meetings took staff away from front facing care and a few staff believed that the phone policy was a "real barrier to care". Although young people spoke positively about their contacts with medical staff, some nursing staff expressed frustration regarding "lack of availability" of medical staff and a perception that the unit "operates in too much of a medical model and appears to use medication as a first line of intervention". Not having social work as part of the team was also an issue as collaboration with local social work teams was described as poor leading to delayed discharges often based on social work having different thresholds before offering support.

Advocacy

What we expect:

The Mental Health (Care and Treatment) (Scotland) Act 2003 is clear about the vital importance of independent advocacy to ensure people's own voices are heard. Young people and adults have a legal right to independent advocacy whether they are subject to compulsory measures under the act or not. This right applies to everyone with a mental illness, personality disorder, learning disability, dementia or related condition, and to all types of independent advocacy[6]. Section 259 of the Act enshrines this in law.

We therefore expect that all patients are offered independent advocacy support. We would expect commissioned advocacy services to include specific advocacy expertise to enable young people to have as much control and influence on their care and treatment as possible given their current circumstances.

What we heard:

The advocacy service, Partners in Advocacy, is not a specialist service for children. They told us they were working with 16 of the young people at Skye House when we visited. Whilst we did not speak with individual advocacy workers, the service confirmed their view that advocacy was valued and respected in this setting. They told us:

"Skye House is really welcoming of advocacy and is always accommodating with supporting us to schedule visits, calls and rooms to meet with young people. Usually in school breaks like summer, Easter, Christmas break etc. We run advocacy groups with young people, awareness sessions and this allows us to do an element of connecting with young people in a group session as well as progressing collective advocacy for the patients. This is encouraged by Skye House".

The service reflected on their child protection responsibilities and confirmed that their

staff would have no hesitation in escalating any matters of concern that they were aware of at Skye House.

Mental Health Officers

What we expect:

Mental health officers (MHOs) have statutory powers under the Mental Health Act to support the care and treatment of people whose mental health condition may require the protection afforded by legislation.

As social workers, MHO's responsibilities include care planning, assessing mental health need and whether compulsory intervention may be required as well as ensuring the rights and welfare of individuals is protected. It is a critically important role and we would expect active involvement by MHOs in the care of young people whose liberty has been impacted by detention in hospital against their wishes. We would also expect that each young person has a current and relevant social circumstances report (SCR) on file which has been sent to the key recipient, the responsible medical officer and copied to the Commission (section 231 Mental Health Act). The content of an SCR is clearly set out in the Mental Health (Social Circumstances Reports) (Scotland) Regulations 2005 and their purpose in the Code of Practice (Volume 1 Chapter 11). The Commission has published good practice guidance in relation to SCR provision[7] and also monitors the provision of these statutory reports.

What we heard:

15 MHOs provided their views as part of this visit/inspection process. All were involved in working in partnership with the young people currently on the unit. MHO visits to the ward were based on the needs of the individual young person but were generally regular with one MHO describing visiting four times over a six-week period and another two to three visits per week.

"2 x weekly prior to the granting of the CTO with 1 x fortnightly contact since this time".

Eight of the MHOs said they were routinely invited to the multidisciplinary ward meetings (one only after requesting to do so), three others were not invited but two of these MHOs were satisfied that they received comprehensive written updates instead from the nurse manager.

Four MHOs had identified concerns currently or previously; some had raised multiple concerns over several years invoking procedures relating to child protection, adult support and protection, escalation to managers, and senior ward staff in order to address. Other MHOs noted no concerns in the course of their work but felt able to raise matters either with the nursing staff, the responsible medical officer, their line manager, the Commission or via child/adult support and protection procedures as appropriate. Where concerns had been raised with the multidisciplinary team previously, this was not always thought to be welcome and led to what was described as fractured relationships.

12 of the 15 MHOs confirmed that they feel they are confident and competent in relation to their child protection/adult protection responsibilities, most of whom provided further details of their extensive experience and qualifications in this area.

Social circumstances reports (SCRs) were reportedly prepared or being prepared for nine of the young people (we could only locate three completed in records). We expected to see 22 reports completed or in progress. One MHO was of the view that completing a compulsory treatment order application negated the need for a social circumstances report, not appreciating the different purposes. Other MHOs explained that their workload prevented them from completing the reports required in law. National standards for MHO services[8] are clear that MHOs are required to fulfil their statutory duties under the legislation in accordance with the principles of the legislation and the associated Codes of Practice and managers require to enable this. Whilst an SCR may serve little or no practical purpose, this should be stated and the reason should not be that the social work department is too busy.

MHOs generally spoke positively about their current experience of the unit, the "care and compassion" shown to young people and the approachability of staff. One MHO new to Skye House wished to highlight that he feels the unit has *"been particularly good at including and consulting the family relating to care plans and meal planning".* Current issues which were being picked up and escalated by MHOs related to poor communication and questions about the level of restrictions in place.

What else did we hear and learn?

What we expect:

We expect a culture of openness and respect for the Commission's duty in law to seek and receive a wide range of information including access to patient records. We also expect leaders to facilitate this process and to support their staff during the time the Commission and Healthcare Improvement Scotland are both on and off site.

What we found:

All operational staff we spoke with across the range of disciplines spoke openly about what works well at Skye House and what the barriers are.

We noted a busier atmosphere during the second week of our visit and were told by staff that extra staff had in fact been sent to the unit during the first week of our joint visit/inspection. We were told that our first week therefore *"gave a false impression of routine and regular practice in Skye House";* the second week was more realistic.

Some staff reflected on previous years where requests were made to close wards because of concerns about safe staffing and the complex behaviours of some young people. We were told that this was not always listened to and led to significant 'near misses' and was said to be a traumatic time for the team, leading to burn out, particularly for nursing staff. It was said that things have *"come a long way"* since then although staffing resources remain a significant challenge. The service subsequently advised that there have indeed been occasions where beds have been closed in

response to service pressures.

Some staff also spoke candidly about the television documentary and the impact this had on them whilst others joined Skye House post the BBC programme and told us they *"had an expectation of what the culture would be like and it is not like that".* They explained that the environment was far more therapeutic and less behavioural than anticipated although noted *"not completely there in terms of trauma informed".*

The following are the key findings which emerged from what we heard, what we observed and what we read in case records, cross referencing with incident records.

Key findings

Physical health care nurse role

The new role of a nurse who focused on physical healthcare was felt to be beneficial. The role involved liaison with the tissue viability nurses in regard to wound care and the dressings best to use for the young people who have self-harm wounds. An easy read guide was developed to support Skye House staff describe wounds in records so there is a consistent assessment of wounds and healing. Laminated copies of this guide were seen in the treatment rooms.

HEPMA (electronic information system)

It was noted on HEPMA (electronic system) that there was a clozapine titration alert pop up. This alerts staff to symptoms to look out for including tachycardia and shortness of breath.

Care manager and bed manager roles

Care manager and bed manager roles were seen by all as a positive development. Families reported feeling they were a point of contact and young people felt they were a familiar presence in their meetings. We saw in notes how they coordinated care between the professionals and tried to keep in contact with local community teams.

Reflective practice group

We heard that there was a reflective practice group which was valued by members of staff from across the disciplines, though it could be difficult to attend due to staffing issues. We heard how the group is a space that allows staff to discuss the demands that staff need to juggle regularly to navigate complex situations to support the young people.

Staffing

Staffing levels are a significant issue at Skye House. While there are good recruitment and retention rates the current staffing numbers across the multidisciplinary professional groups are insufficient for the needs of the service. Several young people reported having to wait for input with occupational therapy, psychology and dietetics.

We learned that nursing staff regularly worked additional hours to ensure essential patient care was delivered and there was also a reliance on bank staff. We were told newly qualified nurses were given maximum responsibility with minimum experience. Nursing staff shortages were even more pronounced on night shift, 19:30pm–07:30am, with two staff per each ward area plus one charge nurse between the wards. We were concerned that prior to bedtime there were only two staff trying to support eight young people. Commission staff who were present in the wards in the evening found it hard to locate staff.

Young people and their families spoke about the regular use of bank staff or staff from adult wards. There was little confidence in staff attending on a temporary basis. It was said that they did not understand how to interact with teenagers, did not always understand individual behaviours or meal support and did not always have up to date information about the young people. This led to some young people saying they felt misunderstood and families explaining that the use of bank staff impacted communication.

The increased acuity and complexity of needs of young people in Skye House over the last few years has been recognized and indeed a safe staffing tool highlighted the need to recruit 20 extra nursing staff two years ago. We heard some action is only now progressing to address this known gap in substantive resource. Healthcare Improvement Scotland discuss staffing levels and standards expected later in this report.

Culture

There was consistent feedback from all that staff are too busy and this impacted on the ability to spend time and build relationships with young people and their families.

There was also a strong theme that some staff could not be relied upon to be compassionate or empathetic. We heard this from temporary staff supporting the ward and noted records which were not professionally written. Some young people also told us about experiences with staff where they had felt belittled and bullied, we also heard from other young people and families who had witnessed this. One young person told us she had been told she was “pathetic’’ and was “selfish’’ for needing to have a nasogastric tube feed as it took care away from other young people. Another told us that if she was bleeding from a self-harm wound some nurses would not clean blood from her face before walking through the ward area to the treatment room (most would), which felt punitive. Another young person told us they had felt demeaned by a nurse for not using what the nurse considered *“correct language’’* and that they had also witnessed another young person being mocked for self-harming. Some families also reported a lack of compassionate response to their young people at times.

“Skye House is not a nurturing environment”

“…there is a bullying culture”.

Young people who told us about these incidents stressed that this was a minority of the nurses and they felt well cared for by most staff. Likewise, a relative explained *“some bank staff and 10-20% staff do not have a good attitude”.* The impression given was that

a minority of staff believed that some young people chose to behave in the way they did and depending on diagnosis and presenting behaviours were less deserving of the care. This seemed particularly apparent where the young people had had several admissions. These allegations were brought to the attention of the service during our visit. Senior managers held further discussions with Healthcare Improvement Scotland regarding this, please see later in this report for further details.

Some parents who had experience of the unit over the last few years felt there had been an improvement in culture over this time, one felt it was similar. One parent new to the unit said, *"I've certainly not experienced anything like what was discussed in the documentary".*

Staff felt that senior managers' focus after the television documentary was about "managing the optics" rather than true transparency and recognition of the well documented staffing issues which they feel had been largely ignored. A number of staff expressed their disappointment. A recommendation is made at the end of this report in relation to culture.

Use of restraint

There is no specific piece of legislation or Scottish guidance dealing with restraint setting out what is lawful in a hospital and what is not. The National Institute for Health and Care Excellence (NICE), provides guidance on the use of restraint for children and young people (NG10)[9] and although it refers to English legislation, the principles can inform practice and local policies in Scotland. All practice however, should be informed by human rights law, specifically Article 3 (prohibition on torture, inhuman and degrading treatment), Article 8 (respect for autonomy, physical and psychological integrity) and Article 14 (non-discrimination).

Where restraint is considered necessary it should be the minimum required to deal with the agreed risk, applied for the minimum possible time[10].The National Safety Council suggest ideally having up to five people present to safely control a patient[11].

11 of the 24 young people at Skye House had experienced restraint during their admission, some no longer required this intervention and for most of the young people we spoke with restraint was limited to two person redirection or arm holds.

We found the restraint that was undertaken was proportionate and required to manage the risks the young person posed to themselves or others at the time. We noted work done to encourage and support the young people who required nasogastric tube (NGT) feeding to have this intervention with the minimal restraint required.

We asked if the management of aggression team were involved and gave advice about holds where staff felt there were difficulties doing this safely and were told they were. There was evidence that this team had been consulted for two young people in the unit prior to our visit.

Where staff struggled to undertake a restraint safely and according to policy it was stopped and a review was sought from the management of aggression team. There

were times when young people could not be safely fed as they would require to be held but there were insufficient staff. This was recorded on the incident management system (Datix), but it is unclear if any actions were taken regarding this or what governance process was involved.

We noted inconsistent recording of restraint in case records with most detailing the type of restraint, where the restraint occurred and how many staff were involved. On reviewing the Datix incident reports we found similar inconsistencies with some being more detailed than others. All detailed staff numbers involved and length of restraint, but some missed detail of the type of hold used. All records reviewed appeared proportionate to the level of risk being managed. We were pleased to see follow-up discussions noted in Datix records where staff were supported by managers or in supervision to reflect on the incident.

We heard about the recording of multiple incidents on a single Datix and witnessed this in the notes. This means that where there were multiple incidents of restraint it would be recorded only as one. The management team in Skye House is aware of this practice and the implications for inaccuracies in incident recording (under-reporting) but feel there is not staff capacity to complete a Datix record for each incident.

Mealtimes and Naso-Gastric tube feed (NGT)

UK best practice guidelines[12] for nasogastric tube (NGT) feeding under restraint confirms that this practice should always be a measure of last resort when best efforts to support oral nutrition fail with subsequent deterioration in physical health. Whilst it is recognised that NGT feeding under restraint may be required in 'lifesaving circumstances', these circumstances are not clearly defined and require to be determined by the full multidisciplinary team.

Six young people were requiring NGT feeds during the weeks we visited.

Mealtimes were supported with 1:1 support, as required, in the dining room. There were mealtime passports for young people who were diagnosed with an eating disorder. These outlined for staff how to manage mealtime support and what the young person's preference was. The young people reported these were helpful but found it difficult to have staff brought in from other areas or bank staff provide mealtime support. They said this happened regularly.

Parents were involved in mealtime support; we heard this would be in preparation for discharge and involved some education and support sessions for parents. Some parents we spoke to reported feeling unsupported with these sessions and not receiving sufficient advice; they felt they were being used to address gaps in staffing rather than as a treatment process.

Young people were all offered meals and attempts were made to suit their specific tastes, including special diets (for example, vegan) however this was in the context of restrictions of the hospital provisions.

If young people did not manage their meal plan or part of it, they were offered the

corresponding amount of a meal replacement drink, this was clearly set out in individualised meal plans. Young people had a set amount of time to drink this supplement and if it was not managed in the set time an NGT feed would be given and could include the previous snack if missed. The young person would be offered a further chance to drink their supplement prior to the NGT if they asked for this. The British Dietetics Association's best practice guidance (page 1) does not refer to 'if the person asked for this' it states "At the point of passing NGT the patient should be offered another opportunity to take nutritional supplements / water orally in order to ensure that least restrictive practice is being carried out and that every opportunity to take oral food and fluid has been offered".

NGT feeds were mainly done in the treatment room, but where a young person struggled, and staff had difficulty moving them safely to the room, they might be fed in a communal area. When this was required, staff moved the other young people to other areas of the ward and would screen the young person to ensure their privacy and dignity.

Multidisciplinary team working

The team appeared to have a good understanding of each other's roles and respected these though nursing and psychology staff said that psychiatry staff would not always consult or value the opinions of the wider multidisciplinary team. There was access to allied health professionals for young people and their contribution was reflected in the care notes. The art therapist had regular sessions in the unit and these were seen as beneficial by young people who were able to access them. We were disappointed to hear when we visited, that this service was not going to continue to be funded so would not be available in the future. We were however, pleased to hear following our visit that new funding was identified and this service will continue.

The overall low staff numbers in each discipline appeared to make it difficult to achieve a co-ordinated multi-disciplinary approach to care. It caused delays in assessments and agreed multidisciplinary team actions being completed. This impacted on the treatment plan for young people and their families, and we were told that this meant that some young people were discharged without the full assessment that had been agreed.

The social work post at Skye House has been vacant for around three years. It is unclear if there are plans to replace this role or, if not, how social work views and knowledge can be accessed. Attempts to collaborate with locality social work teams were said to be difficult. The QNIC standards recommend there should be 2 full time social workers in a unit with 24 young people so this is clearly a gap.

The weekly, multidisciplinary public protection meeting held in Skye House did not have social work representation and we found there to be gaps in the local processes when and if child protection/adult support protection was considered or discussed in cases where there was self-harm or allegations of harm by staff (noted in Datix for example). Whilst the meeting was a welcome approach, assurance was not given that if harm was identified it would be reported through appropriate procedures immediately and in the same way in the unit, as it would be out with the unit. Healthcare Improvement

Scotland discuss public protection and allegations against staff further later in this report.

There are 9.6 whole time equivalent teachers plus a headteacher providing education to the young people. They are employed by Glasgow City Council and told us they feel very much part of the Skye House team and are “always talking” together.

Care planning

The service has recently moved over to a new care plan template for child and adolescent mental health services (CAMHS). This covers 8 domains; mental health legislation and legal rights; my mental health support team; my mental health care; my physical health care; my family; my safety and time out; my medication and my community and future plan. Skye House uses the FACE CARAS risk assessment which includes a management plan and the St Andrews Nutrition Screening Instrument (SANSI).

We found the care plans did not address meaningful activity/education or spiritual needs. Within the ‘my mental health care’ section we would have expected to find continuous intervention plans if needed, NGT plans if used, and stress and distress plans. It appeared staff were unclear where plans should be placed and some were missed out. We did not see any care plans relating to the use of restraint, NGT feeds, or continuous intervention within the e-health records. When these interventions are being used or anticipated we would expect to see a detailed care plan with de-escalation plan, steps to be taken and ways to reduce distress.

Seclusion was recorded well in notes with timings and reviews detailed and there was a seclusion plan in the record. There were good seclusion care plans for two individuals in part of the unit but we did not find a plan for an individual who was in a different part of Skye House.

There was a lack of care planning around self-harm behaviours. An example being that when one young person was engaging in head banging, the response of staff and the threshold for intervening appeared to be dependent on the staff member and there were no care plans to guide the response.

Care plans seemed to take some time to be completed initially – we found four young people did not have any care plans and those that did, in the main, did not have an initial 72-hour care plan that we would expect to see on admission.

There was a variable approach to the use of the sections in the template, some with quality, inclusive information and others with statements rather than individualized goals and outcomes. Care plans were reviewed weekly, although there was a lack of true summative review with ‘reviews’ sometimes only noting “reviewed on (date) – nil changes”.

The risk summary that was completed prior to admission and was part of the referral process contained good information and ensured risks that had been identified in the community were effectively shared with the inpatient team. We, however, did not see

risk management plans completed for the young people; this was a cause of concern given the level of risk some of the young people were identified as posing to themselves and /or others. Risk assessments were updated weekly with any new risks added or risks no longer present archived, some risks were missed, notably vulnerability.

We heard from staff, families and young people that discharges were discussed with them. The incomplete discharge plan templates and the lack of documented goals to achieve discharge with associated time scales meant it was difficult to fully plan the young person's journey from assessment and treatment to discharge in a cohesive way. Some families felt their views were not fully acknowledged or considered in the discharge planning process with discharges going ahead when families did not feel prepared.

The EMIS electronic patient system used at Skye House is currently more like a filing system for information with pockets of good, person-centred approaches and assessments spread across different areas. The notes in Skye House provide information spread across many recording systems with a lack of a cohesive plan that professionals could use to plan assessment, care, treatment and discharge. Work needs to be done to improve this and get 'buy in' from staff. We were told: *"There isn't enough time to complete care plans and the care plan document keeps changing anyway. It isn't fit for purpose. 30 pages of drivel".*

A requirement for improvement in relation to care planning, risk assessment and risk management is made at the end of this report.

Mental Health Act legislation / authority to treat

The Mental Health Act provides the authority for compulsory treatment of individuals under strict circumstances and describes important safeguards for individuals as to how medical treatment, such as medication, NGT feeding and ECT may be lawfully authorised. Part 16 of the 2003 Mental Health Act[13] describes these requirements which seek to ensure that the rights of patients are sufficiently upheld and protected at a time when they are unwell and may be unwilling to receive treatment or be admitted to hospital on a voluntary basis.

We found a case where despite weekly pharmacy meetings, the appropriate treatment form had not been in place for five weeks. We also found treatment forms which were not reviewed following changes to medication with one person being prescribed a higher dose of medication than was authorized or where the route of administration was not clearly stated. This was raised with the service on the day and rectified. There appeared to be some confusion around urgent medical treatment notification forms being used in a planned way and in advance of treatment (NGT feeds) in some cases meaning some young people were fed without correct legal authority. This was discussed with medical staff who were advised that the young people involved, and their named person should be informed of this together with their right to legal advice; we asked for these letters to be copied to the Commission. The service has since addressed this issue as advised.

We also found an issue where the responsible medical officer authorising the treatment

was not qualified as a child specialist, neither was the doctor giving the second opinion – this meant valid treatment authority was not in place. This was raised with the service and medical staff advised that young people and their named person should be informed of this and their right to legal advice with letters copied to the Commission.

We were told there was no official auditing of medical treatment forms but instead nurses carry out a routine "task" to check these on a weekly basis. We advised of the need to implement a robust system of audit involving the MDT to support the early identification of these matters. The service has since implemented this, as recommended, starting in December 2025.

The electronic system, HEPMA, held copies of treatment forms but uploaded screenshots did not include the date the treatment was authorized until. On the first day of our visit, it was noted that not all treatment forms were filed on HEPMA but by the end of our visit all were uploaded.

Each ward had a folder with each patient's mental health act paperwork and copies of their treatment forms. At the drug rounds we observed, each individual's medications were verified by checking the paper copies of treatment forms. Nursing staff sought assurance that prescribed medication on HEPMA corresponded with the paper forms and that these were the most relevant authority to treat forms.

Observation of the treatment room was that it contained medication stored in a setting which was uncomfortably warm. Nursing staff described that working in such a high temperature affected their concentration levels and had an influence on their ability to administer medication and support NGT feeding in the treatment room. Staff explained that the temperature issue had been escalated by numerous staff, but no solution has been found to address this issue. A requirement is therefore made at the end of this report in relation to maintenance and timely repairs of heating systems. Healthcare Improvement Scotland discussed this further with senior managers of Skye House, for further details please see later in this report.

Rights and Restrictions

The Commission's good practice guidance on Specified Persons[14] is clear that people who are in hospital should be able to keep contact with friends and family throughout their stay, and should, if appropriate, be able to carry on with their lives in as usual a manner as possible. However, it is possible to use section 284 of the mental health act and associated regulations to intervene in the use of a mobile phone where restrictions are assessed and deemed as necessary by the responsible medical officer. We were concerned about the blanket policy underpinning mobile phone removal and use in Skye House; this was not underpinned by a legislative framework. The exception to this blanket policy related to two young people who were allowed more access to their phones out with the ward policy's prescriptive time slots due to specific health and communication needs.

We were told that young people could use a ward phone at any time rather than their mobile and they could have access to a laptop or tablet if they had one. There appeared to be some confusion about this with some young people and staff telling us there was

no phone use out with the hours noted in the policy. Indeed, a parent told us they were not allowed to speak to their young person because they called the ward out with the fixed time slots.

It is understood that Skye House has experienced several instances of unhelpful group social media conversations used by young people on the wards and there have been instances of young people recording videos of others and posting them online. Whilst the intention is clearly to attempt to balance the need for young people to communicate freely with protecting their privacy and ensuring their safety, we feel the current policy does not reflect a person-centred approach and consideration needs to be given to the legal framework that authorises young people's phones to be removed as per our guidance on specified person.

We were also concerned to note that young people were subject to seclusion but there was no available seclusion policy. While we saw a detailed seclusion plan which incorporated regular reviews by the doctor and nurse in charge, there is a need for an underpinning policy to guide this care and provide effective governance. We welcomed the CAMHS specific guidance on use of seclusion, however, will follow up with Greater Glasgow and Clyde Health Board to receive a copy of the Health Board wide seclusion policy to which this should relate, to ensure consistency of practice across the Board area. A recommendation therefore is made at the end of this report.

Activity / Education

The occupational therapist, activity nurse and support worker were very enthusiastic. Some young people however complained that the activities that were organised were very arts and crafts or beauty based, little to do for boys or for those interested in sports. Two of the TVs in two of the three wards were broken when we visited.

Parents/relatives and young people said there was little to do in the evenings or at weekends and that nursing staff had no time to do anything. Nurses confirmed this and missed being able to do the activities they feel they were previously able to undertake. A requirement is made at the end of this report to ensure improvement in provision.

There were many young people in the unit with known/suspected neuro diversity, difficulty in self-motivating or with a tendency to self-isolate, who appeared to spend long periods of time in their rooms, partly by choice. Nursing staff had to prioritise direct care so there was little time available to try to find bespoke activities to capture interest and engagement.

Decisions about attending Stobhill School depended on the young person's willingness and ability to manage school as well as the local authority they live in. Young people and their families were very aware that there was disparity in the level of access to education. We learned, for example, that West Dunbartonshire do not fund young people's education at Stobhill unless there are very exceptional circumstances, other areas had funding caps in place (for example, Stirling x2 periods of schooling per day) and others ensured education was available according to the young person's needs (Falkirk, North Lanarkshire).

We were told that there are frequently young people who would enjoy and benefit from much more teaching but they are not allowed to have it. Equity of access to education based on individual needs is critically important for young people. A national approach needs to be taken to ensure this.

Family Involvement

We spoke to 20 families, many of whom singled out excellent nursing staff with particular praise for the invaluable contacts with care managers.

Opinion on bank staff was less positive because parents/relatives did not feel that they knew their young people well enough.

In addition, concern was expressed about the attitudes of some specific members of nursing staff where they felt that they could be dismissive, condescending and unhelpful. Some families described an "authoritative" approach and felt their young people were not given any autonomy or respect by certain staff members. Many parents/relatives said that, while they were listened to when they brought up these and other issues they then felt the follow up was inadequate or absent.

Some families reflected on their apprehension about their young person being admitted to Skye House, having seen the BBC documentary. They described how initially they had visited their young person in Skye House often to check they were safe. They now felt confident that the care provided was of good quality and said now they only visited because they missed them.

Some did highlight concern about young people once admitted, being "educated" around self-harm and the use of ligatures by other young people. New behaviours then developed and became the focus for intervention rather than the original reasons for admission. Nursing staff confirmed this also.

Most families felt they were aware of what was happening with their young person on the ward however, an issue with information sharing showed some staff did not fully understand confidentiality and the importance of listening to parents. The Commission's Carers Consent and Confidentiality good practice guide[15] was left on each ward for information for families and staff and sent to managers. Our Looking after your Rights leaflets[16] for adults and young people were also distributed.

Whilst some of the families had been signposted to their local carer support groups and found them useful for themselves and their other children who could attend young carer groups, none were aware of their rights to an adult carer support plan or young carer statement.

We were pleased to see Skye House holding its first Carers Support group in August 2025 and noted this had been well promoted and each parent /carer invited to it.

Findings requiring action

Culture: significant concerns were raised in relation to the attitudes of some staff, both permanent and supplementary. While this was reported to Skye House managers at the

time of our visit and action taken, this is an issue that requires ongoing investment in culture change. This includes supporting colleagues who witness and hear such attitudes to not tolerate but to address this behaviour directly with their peers/line managers.

There are long standing gaps in staffing at Skye House. Whilst the recent reported commitment to increase nurse staffing levels at Skye House is welcome, implementation and impact underpinned by a robust workforce model is required.

Authority to treat young people should be in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003. Lawful practice and understanding of roles and responsibilities has yet to be embedded at Skye House. There is a need to implement a robust system of audit involving the multidisciplinary team.

Restraint recording requires to be consistent in terms of numbers and detail. Multiple restraints need to be recorded as such to avoid under-reporting.

Social work: we were told that there had previously been a dedicated social work post supporting Skye House. This has not been in place for the past three years. It is unclear if there are plans to replace this role, or if not, how social work views and knowledge can be accessed. Attempts to collaborate with locality social work teams were said to be difficult. The QNIC standards recommend there should be 2 full time social workers in a unit with 24 young people so this is clearly a gap. This requires to be addressed and there needs to be understanding of the value of the social work contribution. This will also enhance understanding of child and adult support and protection understanding and reporting.

The quality of care plans and risk assessments/risk management plans need to improve and be subject to regular audit.

An NHS Greater Glasgow and Clyde seclusion policy needs to be in place to underpin the use of seclusion at Skye House.

Parents/relatives and young people said there was little to do in the evenings or at weekends and that nursing staff had no time to do anything. Nurses confirmed this and missed being able to do the activities they feel they were previously able to undertake. A requirement is made at the end of this report to ensure improvement in provision.

The temperature of the treatment room is impacting on patients, staff and the quality of care. This needs to be addressed. A requirement is made in relation to this area of improvement.

Anyone has a right to make an advance statement, and we recommend that Skye House build the offer of an advance statement into practice when the person is well, as part of discharge planning.

The visiting areas at Skye House require to be upgraded.

Inequitable access to education is a significant concern highlighted from this visit/inspection. This is not an area that Skye House has the power to address. We will pick up this issue with the Convention of Scottish Local Authorities (COSLA) and the

Scottish Government. The right to education is a key social and cultural right enshrined in the UN Convention on the Rights of the Child (UNCRC).

Systems, Leadership and Governance

What Healthcare Improvement Scotland did

During our safe delivery of care inspection, we:

- inspected the unit environment
- observed staff practice and interactions with patients
- spoke with young people, relatives/visitors and ward staff, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we asked NHS Greater Glasgow and Clyde to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and inform the virtual discussion sessions.

Clear vision and purpose

Skye House is the regional specialist inpatient unit for young people from the West of Scotland. Skye House has a dedicated school known as Stobhill School which has an indoor gymnasium and outdoor spaces. Staff told us each young person has an allocated care manager who coordinates the young person's care and is the key point of contact for carers and families.

As noted previously, Skye House is a 24 bedded Tier 4 specialist Child and Adolescent Mental Health Inpatient Unit based in the Stobhill Campus Glasgow. Child and Adolescent Mental Health Tier 4 services are highly specialised units, for young people who require assessment and treatment for complex mental health needs.

Skye House comprises of three buildings, the inpatient unit, therapies building and Skye House School building. The inpatient unit has three wings Mull, Harris and Lewis. Each wing has eight bedrooms, a treatment room, lounge room and a consultation room, there is also a main treatment room for all three wings and one dining room. The therapies building has art therapy and occupational therapy rooms plus various rooms to enable private space for meetings between staff and young people and their families.

There was one empty patient room on the first day of our onsite inspection, staff advised inspectors that this room had not been in use as it required maintenance. The room was re-opened on the second day of our inspection. Senior managers advised that referrals for admission are prioritised on the basis of clinical need in combination with consideration of available safe care that can be provided in the community. All referrals for admission are received via consultant child and adolescent mental health psychiatrists.

From March 2023-March 2024, 34.2% of young people under the age of 18 were admitted out with NHS specialist child and adolescent mental health services across Scotland (Public Health Scotland Quality Indicator profile for Mental Health, November 2024). There were no young people waiting admission to Skye House during our onsite

inspection. However, we can see in evidence provided that during the week of the 28 August, one young person had been admitted to an adult mental health ward due to a lack of an available bed at Skye House. We asked senior managers what processes are in place when young people are admitted to other areas whilst awaiting a bed. We were advised that as the regional unit for the West of Scotland that each NHS board within the catchment area for Skye House have local policies relating to where young people will be admitted to whilst awaiting a bed. This can include a general paediatric ward or adult mental health ward. If a young person is detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and there is no available bed in Skye House, where able, the young person would be admitted to one of the other regional child and adolescent mental health inpatient units, or if appropriate the National Child Psychiatric Inpatient Unit. Skye House has a full time bed manager; part of this role includes oversight of any young people who have been admitted to other hospitals whilst awaiting an available bed including daily communication with the area where the young person is admitted.

Staff advised that additional beds are never utilised at Skye House. An additional bed is a temporary bed that is added to increase capacity during periods of high demand. However, staff advised that they may admit young people to a pass bed in an emergency. A pass is when a young person has planned leave from the unit such as during weekend home leave. We asked senior managers what processes are in place if a young person is admitted to a pass bed and the young person who is on a pass needs to return. We were told that pass beds would only be utilised if there was a confirmed discharge the following day or Monday if over the weekend. We were also advised that the clinical team contacts young people and their families whilst they are on a pass at home to review if the young person's pass is safe to be continued or if there is a likelihood they may need to return to the unit early and that this would be taken into consideration if a young person is admitted into a pass bed.

A delayed discharge refers to situations where a patient, who is clinically ready to leave hospital, cannot do so because the necessary care, support, or accommodation is not available. We can see in evidence provided by NHS Greater Glasgow and Clyde that there were two young people who had a delayed discharge for the week commencing 28 August. As part of our onsite inspection inspectors were able to attend the Skye House weekly business meeting. We observed that delayed discharges were discussed during this meeting including if an extended pass could be used for one young person awaiting discharge. We discussed this with senior managers who advised that the majority of delayed discharges for young people at Skye House were due to young people not having suitable accommodation to be discharged to. The bed manager and care managers role includes liaising with community services and coordinating planned discharges.

Evidence provided by NHS Greater Glasgow and Clyde includes the Skye House young people and carers information booklet. This includes information and links relating to the Mental Health (Care and Treatment) (Scotland) Act 2003. It also includes information such as, unit contacts, admission information, explanation of who is in the multidisciplinary team, daily routine and timetables. It also includes information on how to contact advocacy services. Advocacy services provide independent support to young

people to ensure they have the information needed about their rights and choices. All young people and adults with a mental illness have the right to independent advocacy. Staff advised that advocacy services contact the unit to discuss if there have been any new admissions and will usually attend the unit within the first week of a young person's admission.

Skye House has an open visiting policy and can also utilise iPads for young people to contact their families virtually, as families and carers may have to travel long distances to visit. There is also an available family room for families and carers to stay overnight. We did not have the opportunity to speak with any families of young people during our onsite inspection. However, as noted earlier in this report the Commission did so as part of our joint approach.

Staff told inspectors that each young person admitted to Skye House will be allocated a care manager who will coordinate the young person's care including liaising with their community child and adolescent mental health services team. Senior managers advised that part of the care manager role includes being the key point of contact for young people's carers and families. This includes the opportunity for weekly meetings where families/carers can be provided with updates about the young person's care and ask any questions they may have.

Skye House School is located in a separate building within the grounds which is staffed by teachers employed by the Hospital Education Service. The school has a dedicated school nurse, health care support worker role. Part of this role includes accompanying young people from the inpatient unit to the school and supporting them during school time. The school has an indoor gymnasium and outdoor spaces as well as access to an outdoor multi-use games area. Staff told inspectors that young people can be taught either individually or in small class groups and if young people are unable to attend the school that education can be provided in their rooms. The length of time young people attend school is assessed on an individual basis and is factored into their individual plan of care. We were also advised that core subjects such as English and maths are taught on the school curriculum and that young people can complete national courses and sit exams whilst at the school. There is also music and art therapy provision provided at the school.

NHS boards play a crucial role in child and adult support and protection. Adult and child protection training provides staff with the information required to promote the protection and wellbeing of adults and children. It also highlights the process to follow if staff are concerned that a person has been or is at risk of being harmed. We asked NHS Greater Glasgow and Clyde for staff training figures for both adult and child support and protection which shows that 100% of staff across the multidisciplinary team have completed public protection training. Senior managers confirmed that this includes both adult and child protection.

We asked NHS Greater Glasgow and Clyde to provide evidence of any incidents or adverse events reported by staff through the electronic incident reporting system for the six months prior to our inspection. One incident reported related to a delay in an initial inter-agency referral discussion taking place after Skye House staff submitted a

child protection notification of concern. A child protection notification of concern is submitted to the police or social work when there are concerns that a child or young person may be at risk of abuse or neglect. An inter-agency referral discussion which commonly follows submission of a notification of concern is the start of the formal process of information sharing, assessment, analysis and decision making following a reported concern. We can see in evidence provided that a contributory factor to the delay in the inter-agency referral discussion taking place arose as the child of concern resided in a local authority out with NHS Greater Glasgow and Clyde. Skye House staff have since liaised with NHS public protection leads from each of the West of Scotland health boards who may have young people from their board admitted to Skye House to gather their current processes for raising a notification of concern. This has enabled collective oversight of relevant health boards processes to help mitigate the risk of delays when managing child protection concerns involving children and young people from health boards out with NHS Greater Glasgow and Clyde.

Evidence provided includes the standard Operating Procedure – Public Protection Skye House AIPU. This includes a flowchart for staff to follow when submitting a notification of concern. Senior managers also advised that there is a weekly public protection meeting. This includes senior staff from Skye House multidisciplinary team including psychiatry, psychology, nursing staff, care managers and clinical service managers. Documentation is completed during the meeting which maintains a chronology of any public protection concerns for individual young people at Skye House. We were provided with a copy of this document from the meeting on the 21 October 2025. We can see from this that documentation includes any discussion with Greater Glasgow and Clyde public protection team, when notifications of concern were submitted and police contacted. Any weekly updates are also documented. Senior managers advised that the document is uploaded onto the Skye House electronic system so staff can access when required. Whilst we recognise the processes that are in place for the review and oversight of public protection, a requirement has been given to support ongoing improvement in this area. Please see the experience of care and treatment part of this report for further information.

NHS boards have a responsibility to comply with fire safety standards in accordance with NHS Scotland Firecode (2007). We did not observe any obstructions to fire exits during our onsite inspection. As part of the inspection, we asked NHS Greater Glasgow and Clyde for staff fire safety training compliance and fire risk assessment for Skye House. We can see from this that 92% of staff across the multidisciplinary team have completed fire safety training, including 93% of nursing staff. We were also provided with the fire risk assessment and action plan for Skye House completed in June 2025.

The action plan highlights 11 areas for improvement, eight of which were rated as low risk. However, three were rated as medium risk, including ensuring unit staff are sufficiently trained to carry out fire evacuation, fire doors being found to be propped open and having gaps or not fitting properly and fire extinguishers not being serviced annually as per British Standard guidelines.

The fire risk assessment documents that two fire doors were missing, one within Lewis wing and one within Mull. It also gives the recommendation that a fire door survey is

carried out. Evidence provided also includes Scottish Fire and Rescue Service fire safety audit outcome for Skye House for August 2025. This also highlights staff training including evacuation procedures and the need for a fire door survey as areas of improvement. Other areas for improvement included the review of fault lights on the fire alarm panel and the repair of a hole in a ceiling within the therapy building which could compromise fire resistance.

We asked senior managers for an update on the fire risk assessment action plan and areas of improvement that were highlighted by the Scottish Fire and Rescue Service. This update documents that the majority of the actions have been completed with the remaining being actioned and in progress. It is also highlighted that the fire risk assessment incorrectly documents that fire doors have been removed as there have never been fire doors in the areas documented and that this has not been raised as an area of non-compliance during Scottish Fire and Rescue Service inspections. Senior managers advised that fire extinguishers have now been tested with a contract in place to ensure annual testing and the fire door survey has been completed.

Whilst we recognise improvements have been made to meet the recommendations of the fire risk assessment and Scottish Fire and Rescue Service survey a requirement has been given to ensure ongoing compliance with NHS Scotland 'Firecode' guidance.

Leadership and culture

Nursing staff we spoke with were open about ongoing challenges relating to staffing levels and high use of supplementary staff. Senior managers told us of a recent increase in funding to increase the multidisciplinary team establishment including nursing staff and allied health professionals.

The majority of nursing staff we spoke with described a supportive environment within the Skye House team with visible leadership. However, as also reported to the Commission some nursing staff described feeling as though their views were not always taken into account by medical staff. Staff were open about the challenges in relation to staffing levels and acuity and dependency with some staff describing feeling burnt out. Some staff we spoke with described often being late to finish their shift due to workload.

The multidisciplinary team for Skye House includes nursing staff, psychiatric medical staff, psychology staff, family therapy and art and music therapy staff. The allied health professional team comprises of occupational therapy, dietetics, speech and language therapy, physiotherapy and pharmacy although not all of these posts are currently full time. The registered nursing staff establishment includes both mental health and learning disability registered nurses. The current staffing model is based on 10 nursing staff during day shifts and eight nursing staff during the night shift with an aim of comprising of 60% registered nurses and 40% health care support workers. However, staff told us that supplementary staff will be utilised if acuity and dependency levels require higher staffing levels. Evidence provided includes nurse staffing numbers for the week of the 18 August 2025 which shows additional staff were on duty throughout the week. Whilst senior managers advised of the agreed increase in the nursing

establishment this has only recently been agreed, and we do not have an update on the proposed workforce model.

We can see in workforce data provided by NHS Greater Glasgow and Clyde that Skye House currently has two registered nursing vacancies with recruitment under way and no health care support worker vacancies. There is also a full-time vacancy for a speciality doctor. Speciality doctors have at least four years postgraduate experience, two of which are in their chosen speciality. We asked senior managers if this post was currently undergoing a recruitment process and how the vacancy was currently being covered who advised the post has now been successfully recruited into.

Senior managers and staff told us of a proposal to gain additional funding to enable the increase of the workforce establishment for Skye House. We were provided with a briefing paper written by senior managers which was submitted to NHS Greater Glasgow and Clyde board regarding the proposed increase in the workforce model. This highlights the increase since 2020 in the number of young people admitted with eating disorders who may require intensive nursing care including mealtime support or nutrition by artificial means via a nasogastric tube. This increase is in line with national figures, with Scottish child and adolescent mental health services reporting an unprecedented increase in the number and severity of young people presenting with eating disorders since the start of the COVID-19 pandemic.

Senior managers advised that at times of increased acuity and dependency supplementary staff would be utilised if additional staff are required. Supplementary staffing includes substantive staff working additional hours, staff from the NHS board's staff bank or staff from an external agency. A high use of supplementary staff can have an impact on continuity of care as supplementary staff may not be as aware of the young person's individual care needs or preferences. We were able to talk with two young people during our onsite visit both of whom told us that the use of supplementary staff can be frustrating and unsettling due to the number of "new faces".

Inspectors observed that supplementary staff were in place during both days of our inspection. Evidence provided includes the nursing staff figures for the days of our onsite inspection. We can see from this that there is a reliance on the use of supplementary staff particularly health care support workers with a total of 17 out of 50 shifts being covered by bank staff over the 48 hour period. Of the 28 registered nursing shifts, five were filled by bank staff with a further two registered nurses being redeployed from other mental health services including child and adolescent services on both days of our inspection.

NHS Greater Glasgow and Clyde nursing & midwifery bank orientation logbook for registered nurses and midwives explains that orientation shifts enable new bank staff to work in a supernumerary status whilst they become familiar with their role. It also highlights that supernumerary staff cannot book shifts until the logbook has been completed. The logbook includes such things as ward orientation, emergency procedures and fire safety. We were also provided with the nurse bank healthcare support worker induction learning and resource document which includes role specific learning including general orientation checklist, continuous intervention policy and

violence and aggression training. Continuous interventions will be discussed further, later in this report.

An appropriate nursing skill mix is the combination of skills and experience required to meet the acuity and dependency needs of patients. We discussed the use of supplementary staff with senior managers who advised that they do not utilise agency staff but will use bank staff to cover increased acuity and dependency in the unit. We were also told of recent recruitment of a core group of bank staff who had agreed to work regular shifts at Skye House. These staff have been provided with bespoke induction to the unit including training by dietetic staff. Staff told inspectors that whilst there is frequent use of supplementary staff that that they have a cohort of bank staff who are familiar with the ward. However, some staff also told us that they felt the reliance on supplementary staff meant that the skill mix of staff wasn't always appropriate for the acuity and dependency of the young people on the unit.

We raised concerns regarding staffing levels including the reliance on the use of supplementary staff with senior managers during our onsite inspection. We were advised that NHS Greater Glasgow and Clyde had recently recruited a cohort of new staff a number of which are newly registered and would be allocated to the planned child and adolescent mental health service psychiatric intensive care unit at the Stobhill Campus, once it is opened, although there was currently no date for this. We were also told that 15 of these staff would be allocated to Skye House until the intensive care unit was opened.

Workforce pressures including recruitment and retention of staff continue to be experienced throughout NHS Scotland. Support of new staff including newly registered nurses is directly linked to staff retention and health and wellbeing. We asked senior managers how 15 new staff including newly registered staff would be supported when a number of nursing staff had already expressed feeling overwhelmed with the current workload. We were advised that there is a range of induction and support for new staff and all newly registered staff starting in September 2025 will be allocated to a nurse line manager and clinical supervisor. All new staff will be supported by the professional nurse lead and practice development nurse to complete the essential child and adolescent mental health training resource on NHS Education for Scotland digital platform.

Evidence provided includes a number of pathways and procedures for the support and development of newly registered nursing staff. These include the Newly Qualified Nurse (NQN) Pathway for child and adolescent mental health, newly registered nurses summer newsletter, induction timetable and child and adolescent mental health nursing band 5 Core Competency Framework. Skye House also has an establishment of six band 6 charge nurses with the aim of all shifts having a charge nurse on duty to coordinate and provide support to junior staff where able, although this may not always be possible due to last minute absence. Senior managers advised that the senior management team are available in hours and the Stobhill page holder and psychiatric medical team can be contacted out of hours for support.

Having the appropriate skill mix and adequate levels of nursing staff is essential to

ensure safe and effective care. Understaffing and poor skill mix can affect the safety and wellbeing of staff and patients and negatively impact the ability to provide therapeutic interventions. We held a virtual discussion with senior managers of Skye House on Wednesday 8 October who provided an update in relation to staffing and support of newly recruited staff. We were advised that funding has been obtained to increase the establishment of registered nursing staff by approximately 58%. We were also advised that further funding has been obtained to enable the review and increase of the multidisciplinary team including allied health professionals and psychology. Senior nursing cover has been increased with a senior charge nurse providing additional support for three days a week. Senior managers advised that this would enable additional senior nurse cover to provide training and support of new and established staff. We were also advised that the decision had been made to reduce the number of beds at Skye House from 24 to 16 for six months due to increased acuity and dependency of young people in the unit and to enable time to support and develop new staff. Whilst we recognise improvements have been made, a requirement has been given to support ongoing improvement in this area.

Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is to enable clinical leaders to ensure they have protected time and resource to ensure appropriate staffing alongside other professional duties to lead the delivery of safe, high quality and person-centred healthcare. Part of the senior charge nurse role includes leadership, overseeing quality and safety and development of their team including annual appraisals. NHS Greater Glasgow and Clyde adequate time given to clinical leaders (Time to Lead) standard operating procedure documents that senior charge nurses should be allocated 15 hours per week time to lead. During our onsite inspection we were told that due to clinical need within Skye House the senior charge nurse did not always have protected time to lead as was often required to work clinically.

Staff appraisals are essential to enable staff to feel valued, support their development and promote a positive workplace culture. Completed appraisal rates for the staff in Skye House demonstrate that 100% of medical staff have completed appraisals up to June 2025. However, nursing staff appraisal rates were only 64% as of the end of August 2025. We discussed the nursing appraisal rate with senior managers who advised that as well as supporting new staff the additional senior charge nurse cover will enable development and support of all staff including appraisals. Whilst we recognise improvements have been made to ensure staff have time to lead a requirement has been given to ensure ongoing compliance with the Health and Care (Staffing) (Scotland) Act (2019).

The NHS iMatter survey is a staff experience tool which is completed yearly to enable staff, teams and health boards understand and improve staff experience. The survey asks staff to think of their experience in relation to a number of questions. These include but are not exhaustive of questions relating to the team the staff member works in, their direct line manager and organisation. Evidence submitted includes the 2025 iMatter survey results for all three wings at Skye House. We can see from this that all have low response rates with an average of only 31% of surveys being completed.

Scores across all three wings are low for the questions “being given time and resources to support my learning and growth”, “feeling appreciated for the work I do” and “I get enough feedback on how well I do my work”. The iMatter action plans are developed by teams to address areas of improvement highlighted in the iMatter survey. We asked NHS Greater Glasgow and Clyde for the action plans for Skye House. We can see from this that outcomes and actions include staff being provided with dedicated time to attend training, staff having time to complete tasks and the sharing from learning from excellence at monthly charge nurse meetings. NHS Greater Glasgow and Clyde learning from excellence is an electronic platform that enables positive reporting to recognise excellence and feedback to nominated individuals showing them that their work is valued. We can also see from the iMatter results that one wing of the unit has a lower score for overall staff experience. We raised this with senior managers who advised that due to the wing having a number of larger bedrooms that young people with higher acuity and dependency are cared for there. To mitigate this there is a higher ratio of staff, including three band 6 charge nurses allowing for increased visible leadership. Staff are also rotated to work on all three wings of the unit approximately every 18 months or more often if required.

Staff told us of available continuing professional development sessions. Continuing professional development enables staff to learn and develop throughout their career as well as ensuring staff are using evidence-based practice. Evidence provided includes the Specialist Children’s Services Academic Teaching Programme for August to December 2025. Topics include supporting children and young people who have experienced trauma, medication use in child and adolescent mental health services, meaningful occupations, mental health and the role of the occupational therapist and meal support for those with eating disorders. Skye House also has in house continuing professional development sessions which has included understanding avoidant/restrictive food intake disorder and family based treatment in eating disorders.

During our onsite inspection staff told inspectors that they felt comfortable to complete incident reports in relation to staffing concerns. We asked senior managers what support was provided to staff who raise concerns who advised that skill mix and acuity and dependency would be reviewed by the nurse in charge and staff may be moved between each wing to provide support. We were also advised the charge nurse on duty completes regular walk arounds to provide senior support to staff.

We can see in evidence provided that in the six months prior to our inspection there were 721 incidents submitted by staff of which approximately 2% relate to staffing concerns. We recognise that a high number of reported incidents/near misses can indicate a culture of transparency and openness to enable lessons to be learned and promote a safe delivery of care. Senior managers explained the processes are in place for staff to escalate staffing concerns these include discussion at the morning Skye House safety huddle with any concerns being escalated to the Skye House senior management team and Stobhill page holder. Actions recorded in the reported incidents include escalation to the Stobhill page holder, Skye House service manager and nurse bank. It is also documented that the intensive and unscheduled child and adolescent mental health services teams had been contacted to see if they could provide support. However, it is not clear from the incident reports if additional support had been

obtained for all reported incidents although we can see that recorded mitigations include support from the multidisciplinary team, group work and staff redeployment from other areas.

We asked senior managers how feedback and lessons learned from submitted incident reports are shared with staff who report staffing concerns. We were advised that reviewers of the incident report will feedback to the member of staff who has submitted the incident report.

Skye House staff complete a real time daily staffing report. This is an electronic form that provides a real time staffing rating which is completed daily by the nurse in charge. It utilises a traffic light system with red having staffing risks that are unable to be mitigated, amber some emerging concerns but able to mitigate and green no immediate/current concerns. This information is used to help inform service managers of the current position regarding clinical and operational risk within Skye House.

Senior managers advised that staffing including the daily flash report is reviewed daily and escalated to the service manager if red and risk unable to be mitigated. A weekly flash report is also completed to document actual and potential staffing concerns and record mitigations. We reviewed the final draft copy of the real time staffing and risk escalation standard operating procedure for specialist children's services. It is documented that a staffing meeting must occur a minimum of once a day and that this can be via a safety huddle or e-mail exchange. The standard operating procedure is waiting review by the specialist children's services senior management team before being finalised and ratified.

NHS Greater Glasgow and Clyde have recently implemented an electronic real time staffing tool which will include a specific mental health and learning disability tool. Senior managers advised that education and training was provided to staff on how to use the tool prior to its implementation in October. This training will be provided by the quality and transformation team, NHS Greater Glasgow and Clyde health and care staffing team and Healthcare Improvement Scotland.

The Health and Care (Staffing) (Scotland) Act 2019 stipulates that health boards have a duty to follow the Common Staffing Method. This is a multifaceted triangulated approach which includes the completion of a speciality staffing level tool and a professional judgement tool concurrently run to support NHS boards to ensure appropriate staffing and the provision of safe and high quality care.

At our virtual discussion with senior managers in November we were advised that the system is now in place and can see in evidence provided that these have been completed. The Common Staffing Method template is currently undergoing completion.

Whilst it is not documented in any of the incident reports relating to staffing concerns that it resulted in harm to young people or staff, we recognise that during inspection several staff described working under considerable pressure including feeling "burnt out". We asked for sickness absence rates for Skye House staff. We can see from this that in July 2025 15.2% of healthcare support workers and 8.5% of band five registered nurses were on long term sickness absence. Long term sickness absence is defined as a

period that lasts longer than 29 days.

NHS Greater Glasgow and Clyde staff support and wellbeing webpage includes a number of health and wellbeing initiatives. These include self-referral to occupational health for counselling services, financial advice and speak up service. The speak up service enables staff to confidentially raise concerns about patient safety and work conditions. We were advised that Skye House has a civility saves lives champion. 'Civility saves lives' is a campaign that raises awareness of the impact that behaviour, including rudeness can have on staff wellbeing and patient safety in health care settings.

The NHS Greater Glasgow and Clyde wellbeing webpage also includes course dates for the mental health and stress awareness (people management module). This is available for any manager who has responsibility for staff within their teams and includes training on how to assess risks caused by personal or work related stress and the importance of monitoring and review post risk assessment.

In evidence provided approximately 13% of reported incidents include violence and aggression towards staff from young people some of which have resulted in staff injuries which have required sickness absence. We asked senior managers what support and health and wellbeing initiatives are in place for staff involved in incidents of violence and aggression. We were told that the nurse in charge at the time of the incident would provide support to the staff member to assess if any physical injury or impact on psychological wellbeing. If staff require treatment or absence, they will be contacted the following day for support and update. We were also advised there would be a clinical review of the young person's care plan to identify any driver for the violence and aggression with the aim to reduce incidents and support staff and the young person.

During our onsite inspection staff told us of debrief following incidents, and also two weekly reflective practice sessions which they described as helpful. Senior managers advised that debrief sessions can be in the form of rapid or more formal team debrief. Evidence provided includes the least restrictive care debrief guidance. This highlights that all involved including staff, patients and carers are offered the opportunity to take part in the debrief process. We were provided with the Skye House SBAR for team debriefing. Situation, Background, Assessment and Recommendation (SBAR) handover tools have been recognised as an effective way to optimise communication of information. The SBAR includes information on available support for staff such as chaplaincy service, occupational health, peer support and psychology support. Staff also told us clinical supervision is available for all staff but they weren't always able to attend due to acuity and dependency in the ward. Clinical supervision is a proactive process to support development and professional growth by offering dedicated time, feedback, and guidance in a psychologically safe space to critically reflect on practice. If staff are unable to access this due to workload this may impact on staff development and wellbeing and the ability to provide high-quality, safe, person-centred care. A requirement has been given to support improvement in this area.

Prevention and management of violence and aggression training provides healthcare staff with the skills and knowledge to prevent and safely manage incidents of violence

and aggression to promote the safety of staff and patients. We can see in evidence provided that 99% of Skye House staff including nursing, allied health professionals and medical staff have completed prevention and management of violence and aggression online training. We can also see in evidence provided that 81% of nursing staff have completed safe holds training with dates booked for those staff whose training is due to lapse.

NHS Greater Glasgow and Clyde safe care team provides face to face breakaway and safe holds training. Breakaway training teaches staff techniques on how to safely disengage from potentially violent confrontations. The safe care team can also provide individualised safe care support such as early intervention plans and safe hold care plan. They also complete a daily review of submitted incident reports relating to violence and aggression and can provide further advice, additional training or individualised care planning if required.

We asked senior managers what support was available for young people who witnessed episodes of stress and distress who advised staff would link in with young people after any significant events and the multidisciplinary team would be available to provide further support. Stress and distress can include agitation, anxiety and aggression. Personal alarms are available for staff who work within Skye House to enable staff to summon help quickly in an emergency.

Incident reports we reviewed include one where there were not enough available personal alarms for staff and a second where the alarm system had been faulty and only partially repaired. Staff we spoke with also explained that alarms can be difficult to hear in certain areas if the unit is noisy. We discussed this with senior managers to understand mitigations in place if there was a fault in the system or alarms were difficult to hear. We were advised that the system had now been fully tested and was fully functional. We were also advised that if there is an alarm fault in a specific area of the unit that staff will be allocated to that area so they can seek help if needed. When possible, the area where the alarm is faulty can also be closed off to mitigate risk until the fault is fixed. We were also advised that each ward has a pager which will also alert if an alarm is triggered in any area.

Domestic staff we spoke with told us that they do not always carry personal alarms although they are available. We raised this with senior managers who advised that this would be discussed with the domestic team. Senior managers have since advised that personal alarms have now been issued to all domestic staff.

Adverse event reviews help to identify whether the potential harm, or actual harm, associated with the adverse event was avoidable. The Healthcare Improvement Scotland A national framework for reviewing and learning from adverse events in NHS Scotland highlights the expectations, guidance and timeframes for adverse event review. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. Significant adverse event reviews are essential to ensure key learning and reduce the risk of future harm. We can see in evidence provided that there are three significant adverse events under review for Skye House. The commissioning of a

significant adverse event review is essential to ensure lessons are learned and to continually improve safe and effective care. Two of the three significant adverse events under review remain open after six and 12 months. This is not in line with guidance within the national framework which recommends that significant adverse events are commissioned, reviewed and an improvement development plan are completed in 140 days. A requirement has been given to support improvement in this area.

During our onsite inspection staff told us of the introduction of a number of short life working groups as part of improvement initiatives. These include seclusion practice and guidance, care plans and the recording of reported incidents. The electronic incident reporting system utilised by NHS Greater Glasgow and Clyde has category and subcategories for incidents. Senior managers advised that the short life working group will review and improve recording of detail and consistency of submitted incident reports. This will include reviewing categories to see if additional ones should be added to the system to enable more accurate and specific categorisation.

We asked senior managers how any potential risk is mitigated when incident reports are first submitted and are in the holding area prior to being allocated for review. We were advised that any incident reports submitted during the previous 24 hours would be discussed at the Skye House morning safety huddle and actions allocated accordingly. If any actions are required out of hours this will be escalated to the on call management or clinical team. Evidence provided highlights that the Skye House risk management group meets monthly to review the previous months incident reports. We were provided with the minutes of the clinical risk management meeting from June 2025 which discusses the themes from reported incidents and also care planning for young people involved in any incidents.

We reviewed minutes from NHS Greater Glasgow and Clyde specialist children's services Skye House oversight meeting September 2025. These meetings are held every two weeks and have incidents and actions as part of the standing agenda items. As of Sunday 7 September, 80 records were in the holding area with 33 being overdue review with one dating back to May 2025. Actions documented include the establishment of a regular review schedule for incidents. A requirement has been given to support improvement in this area.

Evidence provided by NHS Greater Glasgow and Clyde included a number of policies and procedures which are overdue their review date or in draft form awaiting ratification. These include NHS Greater Glasgow and Clyde guidance on ligatures, the use of big fish safety knife cutters and policy for the management & reduction of violence, aggression, restrictive interventions and physical restraint. We asked senior managers about procedures that are in place for the oversight of policies and procedures who advised that specialist children's services clinical governance group are currently reviewing policies for Skye House. We were also advised that adult mental health services have an allocated senior manager for policy reviews and specialist children's services governance meetings feed into the wider NHS Greater Glasgow and Clyde governance meetings. NHS Greater Glasgow and Clyde mental health services are in the process of adding all existing policy documents to the NHS Greater Glasgow and Clyde MyPsych page of the NHS Right Decisions Platform. This is an electronic platform where NHS

boards can upload resources policies and tools to be readily available for staff. Whilst we recognise improvements are ongoing, a requirement has been given to support improvement in this area to ensure guidance is current and up to date.

Senior managers also advised that The NHS Greater Glasgow and Clyde policy for the management and reduction of violence and aggression, restrictive interventions and physical restraint document is an NHS Greater Glasgow and Clyde health board policy, not a specific mental health policy. We were also told it was highlighted at the mental health governance meeting in March 2025 that the policy was out of date. It was agreed at this meeting that the NHS Greater Glasgow and Clyde safe care team would develop a mental health services policy which is currently under review. The safe care team will be discussed later in this report.

Pathways, procedures and policies

We observed positive and respectful interactions between staff and patients including when a young person was experiencing stress and distress. Staff told us of the recent implementation a new continuous intervention policy and person centred care plan guidance. However, we observed gaps in documentation and young people we spoke with described lack of available activities during the weekends and evenings.

We also observed feedback from young people and their families/carers on display in the main area. This included a section titled “what was really good about your care”. Some of the entries on these from young people and their families/carers included several relating to feeling listened to and staff being supportive. There is also a section titled “was there anything you didn’t like or that needs improving”. This includes several relating to food choice and provision and the dining room environment. These will be discussed later in this report.

We asked senior managers what other processes are in place for families and young people to provide feedback who told us that young people can complete the NHS Greater Glasgow and Clyde experience of service questionnaire report. We were provided with submitted responses for January 2024–July 2025. However, only 17 questionnaires have been completed during this time. We can see from this that whilst there are positive comments relating to staff within Skye House, that there are several negative comments relating to staff attitude towards young people. We asked senior managers how feedback from these questionnaires is shared with staff. We were advised that a report is produced and discussed for action at the Skye House operational management group. Additionally, a member of the team had been allocated to ask young people to complete the questionnaires, however, they often declined. In an aim to improve uptake young people will be reminded of the questionnaire at the fortnightly community meetings. In the alternate week when there is no community meeting the activity coordinator will ask young people if they wish to complete the questionnaire.

During our onsite inspection we were able to speak with two young people who described the majority of staff as supportive and included them in discussions and decisions around their care. In line with their methodology the Commission speak with a greater number of young people and shared with us that the majority of young people

and families they met with were positive about the staff. However, they also identified that some young people told them that some staff were not empathetic or compassionate which had resulted in young people feeling belittled and bullied. We held a virtual discussion with senior managers on Tuesday 28 October to raise concerns relating to the feedback from young people to the Commission. During this meeting senior managers advised that this feedback had been discussed with staff and the human resources department had been asked to provide support. We can see in further evidence provided that on advice of the human resources department that a fact finding exercise would be completed and staff would receive support with clear reaffirmation of expected standards and practice. It is also documented that the feedback provided to the Commission had been discussed with the individual staff members involved.

We were also advised that realistic medicine has been added as a topic for the nurse induction programme to promote greater understanding of care standards and delivering care that recognises the patient as the expert in their own experience. Realistic medicine is an approach to healthcare that aims to put people including patients and carers at the centre of decisions made about their care. Senior managers also told us that civility has been explored during staff meetings and civility champions are being identified from each wing to continue to develop a positive culture. Feedback including concerns raised by staff, families and young people of a safeguarding nature will be reviewed and discussed as part of the multidisciplinary team weekly safeguarding meeting.

We asked senior managers how they ensured young people could feel safe to provide feedback. We were advised of the recent implementation of the daily link worker role where each young person is allocated a specific member of the nursing team. This is recorded on the Skye House noticeboard so young people are aware who their link worker is for the day. Advocacy services are also available for young people and senior managers advised that they are invited to all young people's care plan meetings. We were also advised that the team at Skye House are involving young people to share how they would like to provide feedback and are also considering reaching out to other health boards to see how they seek feedback. The potential of the use of a QR code to enable young people to provide anonymous feedback is also being considered. The advocacy service will also be working with young people to develop a 'young person's council' to include feedback. The use of a traffic light system as a visual tool to support young people to communicate including the tools and language they find helpful to reduce stress and distress is also available. This enables the young person to identify signs that will help staff to recognise if they are becoming stressed or distressed and their preferred methods of support. The traffic light communication tool is kept outside the young persons bed space enabling staff to see any changes which the young person indicates by the movement of the arrow. There is also a copy of the traffic light system in the help us to help you booklet and an information poster displayed in the main corridor of the inpatient unit.

The Skye House help us to help you booklet has been designed by nursing staff and includes areas for young people to record their views on their care plans, ideas for their safety plan such as what may cause them to feel unsafe and what may indicate that the young person is becoming stressed and distressed. We did not have the opportunity to

review if young people had these booklets in use during our onsite inspection.

We asked senior managers what processes and support will be put in place if young people raise allegations against staff. We were advised that the allegation would be discussed with the young person and the staff member. The staff member or young person could be transferred to another wing of the unit if requested or if required until a full review is completed. We were also advised that an incident report would be completed and reviewed as per policy and staff would be supported by their line manager. Incidents would be discussed at the specialist children's services clinical risk group meeting to enable senior manager oversight and advice would be sought from public protection and human resources colleagues if required. We observed six reported incidents where young people had raised allegations in relation to staff behaviour. We can see in evidence provided that investigations have been undertaken in all of these and they have now been concluded with no further actions required. We can also see that advice was sought from the public protection team, allegations escalated to senior managers and police were notified if required. We were also advised that NHS Greater Glasgow and Clyde specialist children's services have a complaints manager who can provide advice and support.

Evidence provided includes the Skye House community group meeting template which includes sections to document "things that work well, things that could be better, additional concerns and actions". The community group is held weekly with young people and members of the clinical team. A written record is kept of this meeting and any actions will be reviewed and fedback at the following meeting.

Further evidence provided includes the specialist children's services Skye House – young person and carer support "What we do for you and how we would like to hear from you" document. This highlights that the document is written for young people and describes how the Skye House team aims to incorporate the views of young people and their carers. The document highlights that feedback on the service can be shared by young people and their families/carers in a number of ways including verbally, in writing, the NHS Greater Glasgow and Clyde online feedback form and NHS care opinion website. The NHS care opinion website is a public independent website where people can share their experience of NHS care. We asked senior managers how the specialist children's services Skye House – young person and carer support, what we do for you and how we would like to hear from you document is shared with young people and carers who advised it had recently been agreed to include this in the young people and carers welcome pack.

Advocacy services provide independent support to young people to ensure they have the information needed about their rights and choices. During our onsite inspection we observed information relating to available advocacy services on display in Skye House. The Skye House information for young people and their carers booklet also has information explaining advocacy services and how to access them. Staff told us that all young people are referred to advocacy services and that there are routine drop-in sessions for young people. We can also see in evidence provided that advocacy services will meet with young people during the summer period to develop a group that is led by young people and will be run to complement the Skye House community group

meetings.

We asked NHS Greater Glasgow and Clyde to provide us with the number of complaints received in the past 12 months relating to services provided by Skye House. We can see from this that a total of nine complaints were received. Of these, two were upheld and one was partially upheld. We were provided with a breakdown of the upheld complaints and can see that full reviews have taken place. Lessons learned from these complaints are being included in the development of clinical standards which will include a focus on how the team engages with young people and their families.

We asked senior managers how lessons learned from complaints were shared with staff to ensure any learning and improvements can be implemented. We were told that complaints are shared with the clinical team and if the need for wider learning is identified this can be shared at the operational management group or nurse meetings. If required, learning can also be shared via the professional lead network. We can see in evidence provided that discussions had taken place with staff involved.

The provision of meaningful activity on mental health wards is said to increase social connectedness, improve psychological wellbeing and is essential to promote wellbeing and recovery. Skye House has a dedicated activities coordinator and occupational therapy provision from Monday to Friday. Activity timetables are developed with the activities coordinator and nursing staff with each young person being provided with a timetable for their room. Occupational therapists and activity coordinators are also invited to the community group meeting where suggestions regarding activities can be raised by young people. However, staff we spoke with told us at times due to increased acuity and dependency that the activities coordinator was required to work within the unit to cover staff shortages but where able would continue activities. Staff also told us that there was no activity coordinator or occupational therapy staff at the weekend and that nursing staff are required to coordinate activities at these times which was often challenging due to the acuity and dependency on the unit. They also described frustration that they did not have time to provide therapeutic activities. The young people and families both we and the Commission spoke with also described that there was nothing to do during the evenings and at the weekends. A requirement has been given to support improvement in this area.

We were provided with the activities timetable for October 2025. This includes group activities from Monday to Friday such as mindfulness, creativity group and games. The mindfulness group aims to provide young people with the strategies to manage stress and increase self-awareness. The quiz and games group during October week were Halloween themed after discussion with young people and the activities coordinator. Ideas for the creative group are generated from the group itself and have included making jewellery, slime, suncatchers and posters. We can see it is documented in the timetable that all planned activities took place.

Skye House has a walking group which is part of a mindful movement group and runs once a week weather permitting and is led by the activities coordinator with the support of physiotherapy staff and nursing staff.

Outdoor spaces in mental health wards play a crucial role in patient wellbeing, recovery, and overall therapeutic care. Inspectors observed that Skye House has a number of outdoor areas including multi use games area and school garden. However, whilst there was good availability of outdoor space, we observed that some areas appeared slightly overgrown but were still usable for young people. Staff told us that whilst the estates department will maintain the garden including cutting grass there is no agreement regarding maintaining flower and vegetable beds and that staff had volunteered to maintain these in the past.

During our onsite inspection staff told us that there is a multidisciplinary meeting (safety huddle) at 09:10 during which any changes are discussed such as continuous intervention changes, risk management changes, any public protection concerns and actions required. We were also advised that positive feedback will also be discussed at the meeting. We were unable to attend the multidisciplinary team meeting during our onsite inspection. However, we were able to attend the Skye House business meeting on the second day of inspection. This meeting was open and inclusive and chaired by the bed manager and provided oversight of potential admissions, discharges and predicted dates of discharge for young people. There was good representation of the multidisciplinary team at the meeting including, pharmacy, psychology, psychiatry, care manager, occupational therapy and the senior charge nurse for Skye House. Delayed discharges were discussed as were any changes for predicted discharge dates.

Staff told us of fortnightly nurse meetings, which include staffing updates as part of the regular agenda. The minutes of these meetings are emailed to staff if they are unable to attend. Evidence provided includes the minutes from July and August 2025 meetings. Within these minutes there is an entry relating to the risk that staff magnetic name badges may become dislodged during safe holds and that a young person may swallow the magnetic part of the badge. During our onsite inspection we observed that not all staff were wearing name badges. We raised this with senior managers who explained that alternatives to magnetic name badges are being sought as badges with pins could also be used to self-harm. We were also told that staff carry NHS Greater Glasgow and Clyde identity badges, but they may be kept in their pockets.

Safe holds

Physical restraint should only be used as a last resort to prevent a person from harming themselves or others or to provide necessary help or treatment. The Mental Welfare Commission highlights that physical restraint should only be implemented by staff who have been fully trained in the methods of restraint. Physical restraint training supports staff in how to apply techniques safely without causing unnecessary harm or distress. Approximately 35% of the incident reports we reviewed relate to the use of physical restraint. NHS Greater Glasgow and Clyde use the term “safe holds” to refer to restraint. Documented reasons for the implementation of safe holds includes the administration of intramuscular medication due to stress and distress, preventing young people from harming themselves or others and the administration of nutrition via nasogastric tube. It is also documented in some but not all incident reports how many staff had been involved in safe holds and if any other intervention had been attempted first such as verbal redirection or oral medication. As previously discussed, 99% of the Skye House

multidisciplinary team are trained in managing violence and aggression. Senior managers confirmed that all supplementary bank staff are also trained in managing violence and aggression. As previously discussed, staff can contact the NHS Greater Glasgow and Clyde safe care team to provide advice and support including individualised care planning for safe holds.

Senior managers advised of plans to implement the Safewards model. This recognises staff and patient modifiers that can have an impact on the rates of conflict and required interactions such as seclusion, medication and safe holds. The Safewards model highlights 10 interventions that can reduce rates of conflict. These include but are not exhaustive of clear mutual expectations, positive words and reassurance. The utilisation of the 10 Safewards interventions has been shown to reduce the incidents of conflict and containment. However, we were not provided with a time frame for implementation.

The National Institute for Clinical Excellence (NICE) highlights that if a face down safe hold is utilised that this should be for the shortest time possible. Approximately 4% of incident reports submitted as evidence related to staff implementing safe holds with the young person in a prone position. The majority of these were to enable the administration of intramuscular medication in response to stress and distress or to prevent significant self-harm. NHS Greater Glasgow and Clyde policy for the management and reduction of violence and aggression, restrictive interventions and physical restraint documents that face down restraint is the most restrictive form of safe hold used within NHS Greater Glasgow and Clyde. It also highlights that where it has been assessed that there is a need for a face down safe hold that all relevant employees must be trained in how to utilise it safely and appropriately and that the person who is in the safe holds breathing must be uninhibited.

We can see that it is documented in one incident report that a young person was returned to face up restraint due to difficulty monitoring the young person's breathing whilst being held in the prone position. Senior managers advised that all staff are trained in the safe use of face down restraint as part of mandatory safe hold training. However, it is taught to only be used as a last resort to maintain the safety of the young person and staff. We can see in evidence provided that the young person had had physical observations recorded after the safe hold and that verbal support and alternative activities, as agreed with the young person in their care plan had been offered prior to the requirement of the safe hold but had been declined. We can also see that the safe care team had provided support to staff including further specialised training.

NHS Greater Glasgow and Clyde management of acutely disturbed or challenging behaviour in adolescents policy (Aged 12-17 years) highlights that intramuscular sedation should only be administered where other measures such as oral medication or de-escalation have been unsuccessful. Within the incident reports submitted in the six months prior to our inspection, approximately nine percent relate to the administration of intramuscular medication for reasons including stress and distress, violence and aggression and to prevent significant self-harm. We can also see that it is documented if other types of de-escalation had been unsuccessful or if oral medication had been

offered and declined.

NHS Greater Glasgow and Clyde management of acutely disturbed or challenging behaviour in adolescents policy (Aged 12-17 years) also documents the mandatory physical observations and monitoring to be carried out following administration of intramuscular sedation. These include responsiveness, temperature, heart and respiratory rate, blood pressure and oxygen saturation levels. It was not clear in incident reports submitted as evidence if physical observations had been recorded. We discussed this with senior managers who advised that physical observations are recorded within the young person's electronic care records or paediatric early warning score chart. We were also advised that it has been recognised that improvement is required and quality improvement work has been commenced to create a standardised proforma to ensure consistent documentation and monitoring post incident. If a young person declines to have physical observations completed such as blood pressure and heart rate, staff will continue to observe the young person every 15 minutes to monitor for changes in physical condition such as respiratory rate.

Scottish Child and Adolescent Mental Health Services have reported an unprecedented increase in the number and severity of young people presenting with eating disorders since the start of the COVID-19 pandemic. More information can be found at Eating Disorders in Scotland .

Eating disorders are serious mental health conditions and include several categories including, anorexia nervosa, bulimia nervosa and binge eating. Eating disorders can affect people of all ages but are most typically present in adolescents. They are serious conditions which can be potentially life threatening. The Scottish Government national review of eating disorders services review summary recommendations (March 2021) documents that eating disorders have the highest mortality of all mental health illnesses.

Senior managers advise that the Skye House eating disorders pathway is currently being updated with the aim to streamline a number of current guidance into one document. This will include reference links to relevant topics such as autism and eating disorders, replacement feeding, physical health management and restrictive intake self-harm. At the time of this inspection the new pathway remains under review. NHS Greater Glasgow and Clyde specialist service for young people and children under the age of 18 who have an eating disorder team are also part of the team reviewing the pathway.

The Royal College of Psychiatrists medical emergencies in eating disorders: guidance on recognition and management highlights that eating disorders can present with life threatening emergencies and that weight loss in children and adolescents is often more acute due to lower body fat stores. The guidance highlights that some people may resist weight gain by any means and compulsory treatment under the relevant legislation may be necessary especially in cases where the level of malnutrition is life threatening. This may require insertion of a nasogastric tube against the patient's will, by staff trained in restraint techniques to enable the administration of nutrition via the nasogastric tube.

Nutrition by artificial means and mealtime support

The Mental Welfare Commission good practice guide for nutrition by artificial means highlights that the Mental Health (Care and Treatment)(Scotland) Act 2003 makes specific reference to the provision of nutrition by artificial means in the absence of consent, more information can be found at Mental Welfare Commission for Scotland Nutrition by artificial means. SIGN guidelines for eating disorders documents that "clinicians should consider whether the Mental Health (Care and Treatment) (Scotland) Act 2003 needs to be invoked when a patient (of any age) declines treatment: There may be a responsibility to provide compulsory treatment if there is a risk to the person's life or to prevent significant deterioration to health and wellbeing. SIGN 164 eating disorders revised August 2022. Scottish Intercollegiate Guidelines Network (SIGN) aim to improve the quality of health care by reducing differences in practice and outcome.

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 documents when treatment may legally be given to patients who are not capable of consenting to treatment. As part of our joint visit to Skye House the Commission reviewed young peoples' care records in relation to the legal authorisation of treatment as noted earlier in this report. During our onsite inspection staff told us that Skye House has a dedicated pharmacist provision for four days a week. The weekly pharmacy meetings are attended by the pharmacist, medical and nursing staff to review young people's medication prescriptions including the review of documentation relating to legal authorisation of treatment.

We were provided with NHS Greater Glasgow and Clyde Skye House inpatient unit standard operating procedure: nasogastric (NG) feeding for patients aged 12-18 years. The purpose of which is described as ensuring safe, effective and least restrictive management of nutrition via nasogastric tube in line with national and local best practice, statutory requirements and service – specific protocols. Least restrictive practice promotes a person centred approach to delivering care whilst minimising the use of restrictive interventions such as physical restraint, seclusion or medication. Appendices include competency assessment for nasogastric tube insertion and administration of nutrition, nasogastric tube confirmation and nutrition record and nutrition via nasogastric tube under restraint checklist of conditions to be met. This includes but is not exhaustive of confirming that the intervention is required to prevent serious harm or death, that legal framework is met, that the multidisciplinary team is involved in the decision and that it is the least restrictive practice and reviewed regularly. We asked senior managers how any documentation would be audited who advised that the mental health combined care assurance tool now reviews confirmation and recording of nasogastric tube placement with the next audit due in November 2025. We also asked senior managers how many nursing staff have completed the competency assessment for the insertion and use of nasogastric tubes who advised all registered nurses at Skye House have been signed off as competent.

During our onsite inspection staff told us that an incident support is submitted when safe holds are required to administer artificial nutrition via a nasogastric tube. We can see that approximately seven percent of incident report submitted as evidence relate to the use of safe holds to administer nutrition via nasogastric tube. It is documented in

one incident report that nursing staff sought advice from the safe care team due to an incident where they were unable to maintain a safe hold and safely administer nutrition. We asked senior managers for an update on this who advised the safe care team had met with staff to provide further advice and support to enable staff to safely maintain a safe hold.

Whilst we and the Commission noted that the majority of these reported incidents include information on how many staff were involved, support provided such as distraction and support post nutrition there are a number where only one incident report appears to have submitted even though the young person has required safe holds for nutrition via nasogastric tube more than once in the day. Whilst we acknowledge that it is good practice that incident reports are being submitted it may affect the accuracy of any audit completed in relation to the number of safe holds utilised if an incident report is not submitted for each episode. As stated earlier, this can lead to under reporting of incidents.

The welcome to Skye House eating disorder programme admission information for young people, parents and carers information leaflet has been designed to provide written information on what will happen when young people are admitted to Skye House for treatment of an eating disorder. This includes information on physical monitoring such as recording weight and height, blood tests and monitoring heart rate and blood pressure. Food plan and mealtime support is also discussed including nursing staff facilitating mealtime support and dietitian support to complete a nutritional assessment and prescribe a food plan to meet individual need.

Within incident reports reviewed, six had been submitted by staff which document that due to reduced staffing availability and increased acuity and dependency staff were unable to provide mealtime support to all young people who required it. A young person may require mealtime support due provide a structured therapeutic intervention as part of a young persons planned care plan.

The majority of these incidents relate to the same two day period. Senior managers advised that whilst there had been one member of staff on sickness absence for both these days that the main cause was due to increased acuity and dependency in the unit due to the numbers of young people requiring mealtime support. Senior managers identified that at the time of the reported incidents mealtime support was not factored into the acuity and dependency of the unit. However, we were also advised that required mealtime support is now included in the acuity and dependency of the unit and additional staff requested if required.

We asked senior managers how risk was mitigated if there were not enough available staff to provide mealtime support who advised staff would link in with other child and adolescent mental health services to ask for support. Shortages would also be escalated to the Stobhill page holder, specialist children's services senior management team and chief nurse for adult mental health services. We were also advised that staff would look at young person's care plan needs to see if the multidisciplinary team could utilise group work to support staff and provide support at mealtimes. However, it is unclear from the incident reports if support was requested or received for all these instances or the

impact on young people not being provided with mealtime support. A requirement has been given to support improvement in this area.

We reviewed feedback from young people relating to poor quality, lack of dietary options and dirty cutlery. The Skye House quality network for inpatient CAMHS focused peer review report November 2024 also highlights that young people had fed back that there was a lack of vegetarian options. Skye House has one dining room which is shared by all three wings. Inspectors observed that mealtimes appeared organised with some young people choosing to eat out with the dining area. However, staff told inspectors that there used to be two dining rooms and now that it was one shared dining room that it could be very noisy. We also observed feedback from young people relating to how busy and intense the dining room could be. We raised this with senior managers who advised that there were now available meal choices including, vegan, vegetarian and halal and the recent introduction of a deli kart which provides baguette options. Whilst we recognise improvements have been made a requirement has been given to support ongoing improvement in this area.

During our onsite inspection staff told us that they felt that increased dietitian support would be beneficial. Staff told us of a recent reduction in cover due to unforeseen circumstances which they felt had caused delays in providing support. Staff also raised concerns that the cover had been provided remotely and not face to face. Face to face consultations and meetings have been shown to enhance the effectiveness of building relationships and communication. We were provided with NHS Greater Glasgow and Clyde specialist children's services inpatient dietetic cover protocol. This explains the process for dietetic cross cover between Skye House, the National Child Psychiatric Inpatient Unit at the Royal Hospital for Children and outpatient specialist eating disorder team including that in most cases this may be via remote meeting and not face to face. As previously discussed, senior managers also told us of the planned increase in establishment of the multidisciplinary team including dietetics. We did not see any incident reports submitted in relation to a delay in dietetic cover. Whilst we recognise NHS Greater Glasgow and Clyde are currently reviewing the allied health professional workforce establishment including dietetic provision a requirement has been given to support improvement in this area.

Self-harm

The National Institute for Health and Care Excellence (NICE) defines self-harm as intentional self-poisoning or injury, irrespective of the apparent purpose. Scotland's self harm strategy and action plan (2023-27) highlights that self-harm is complex and varies widely from individual to individual and can serve a variety of functions. These can include a form of self-punishment, compulsive or habitual behaviour and distraction from distressing emotions. It also documents that self-harm can enable people to regulate emotion, provide release or comfort and restore calm.

A significant number of incident reports submitted in the six months prior to our inspection relate to staff having to intervene to either stop or prevent young people from harming themselves including attempts to use ligatures and other forms of self-harm and self-injurious behaviour. We can see from documentation in incident reports

that it appears staff responded appropriately and intervened, including escalating for immediate medical help and further medical assessment and treatment when required.

Approximately 18% of incident reports submitted in the six months prior to our inspection relate to staff having to intervene due to young people attempting to harm themselves by applying ligatures. It is documented that staff intervened appropriately to remove the ligatures including the use of ligature cutters where required. We cannot see it documented in any of the reported incidents that the ligatures resulted in young people requiring ongoing medical assessment or treatment or that anchor points were used. We did, however, see a small number of reported incidents where young people had tied several ligatures during the course of one day.

We raised this as a concern with senior managers to seek further understanding in relation to young people tying multiple ligatures throughout the day. We were provided with an in depth overview relating to these incidents including, rationale for decisions relating to when and if to commence continuous interventions. This included any mitigations put in place prior to commencing continuous interventions. These include emotional support being provided by nursing staff, the young person spending time in the communal areas and the increase from 15 minute to 5 minute observations from staff. It is also documented in the overview of the incidents that the decision had recently been made to reduce continuous interventions with mitigations in place to promote least restrictive practice. Least restrictive practice promotes person centred care that prioritises an individual rights and wellbeing by using the least intrusive intervention necessary to achieve a safe and affective outcome. Senior managers advised that the reasons for young people attempting to apply ligatures is complex and can include a non-verbal way to express stress and distress.

Annual ligature risk assessments are part of an ongoing programme of assurance within NHS hospitals to reduce the number of incidences of self-harm or suicide by identifying potential ligature points and the controls and mitigations in place to reduce identified risks. We were provided with NHS Greater Glasgow and Clyde Safety Health and Wellbeing (SHaW) risk assessment form for the management and reduction of ligature risk for Skye House. The purpose of the risk assessment is to identify physical ligature points and identify control measures to mitigate risk. We can see that the risk assessment has a risk rating matrix which is documented as being used to support an escalation of risk and consideration with red being very high risk, amber, high, yellow medium and green low. Within the risk assessment risk ratings have been completed and control measures identified. This includes potential ligature anchor points with current control measures including individual risk assessments, reduced ligature design hardware and furniture and consideration of the use of continuous interventions if assessed as required.

Control measures documented in the SHaW risk assessment form include completion and regular updates of young person's risk assessments, care planning and the implementation of continuous interventions. Staff told inspectors that staff complete checks on all young people every 15 mins which is recorded and documented. During our onsite inspection we observed that staff were completing these checks. The checklist sheet was up to date and staff were visible within the communal areas. Skye

House also provides feedback to the NHS Greater Glasgow and Clyde suicide/self-harm risk management group. This provides a monthly overview of self-harm incidents or near misses at Skye House, ongoing training and any improvement opportunities to share as best practice. We were provided with the August 2025 update which includes a brief description and number of incidents and ongoing training and support from safe care team for the use of safe holds.

NHS Greater Glasgow and Clyde utilise electronic patient care records including a child and adolescent mental health risk assessment tool. This provides a structured assessment to enable clinicians to assess and manage risk for young people. These include aggression risk, vulnerability risk and self-harm and suicide risk. Inspectors were able to review two sets of care records during our onsite inspection. We observed that whilst initial risk assessments were completed including risk of self-harm it was not clear how risk was mitigated as there was no corresponding risk management plan. We raised gaps in documentation with senior managers during our onsite inspection. Documentation will be discussed later in this report.

We are aware that a rise in reported self-harm incidents may be attributed to the acuity and dependency of the young people on the unit at the time. NICE guidelines discuss harm minimisation strategies when a person is engaged in ongoing treatment but is not yet in a position to resist the urge to self-harm. Harm minimisation is an approach that accepts a persons continued urge to self-harm whilst aiming to keep long term damage and frequency of injury to a minimum. It highlights that harm minimisation strategies should only be considered in certain circumstances including to reduce the severity and/or recurrence of injury, as part of overall approach to ongoing care and after being discussed with the person and their family and multidisciplinary team.

Approximately 30% of all reported incidents submitted as evidence relate to staff having to intervene due to young people attempting or performing a specific type of self-injurious behaviour. Young people may perform self-injurious behaviour for a number of reasons including stress and distress, self-soothing, communication or response to intrusive thoughts.

It is documented in incident reports that support included verbal support, de-escalation techniques such as use of iPad and offer of oral medication to reduce stress and distress. We can also see documentation where young people have been unable to engage with staff and deescalate that safe holds had been utilised and intramuscular sedation given due to risk of harm. Further documentation includes that actions were in line with the young person's care plan and discussed with the multidisciplinary team. We discussed the number of incidents relating to young people's self-injurious behaviour and mitigations that were in pace with senior managers. We were advised that care plans relating to interventions for escalation and severity would be in place and would be discussed with the young person including that safe holds may be used if increased severity and risk of harm. We also discussed support in place to enable the young person to continue to self sooth and reduce the risk of harm. We can see in submitted incidents that it is recorded that these had been used as per care plan.

We asked senior managers what training is available for staff in relation to the

prevention of self-harm and suicide who advised of twice yearly training in relation to suicide and self-harm prevention and also an annual masterclass. However, we can see in evidence provided that only three staff from Skye House attended the masterclass in 2024 although it is documented that the session is recorded so staff can watch at another time. We were also advised that an interactive session for safety planning and supporting young people at risk of suicide and self-harm will be included in the induction programme for newly registered nurses this year. Senior managers also advised that Skye House has a Teams channel which includes resources relating to prevention of suicide and self-harm. However, self-harm and suicide prevention is not currently part of mandatory training for staff at Skye House. A recommendation has been given to support improvement in this area.

Continuous interventions

Continuous intervention is an enhanced level of care implemented when a patient has elevated levels of risk that cannot be mitigated without continuous, supportive intervention. It should be specific, therapeutic and purposeful, as least restrictive as possible and in line with the patient's needs. Within a number of the incident reports we reviewed, continuous interventions had been implemented to mitigate the risk of self-harm.

NHS Greater Glasgow and Clyde implemented a new continuous intervention policy and practice guidance in March 2025. We can see in evidence provided that the policy was developed in accordance with Healthcare Improvement Scotland guidance 'From Observation to Intervention.' For more information please see here. This aims to support mental health practitioners to move away from the traditional practice of enhanced observations and work towards a patient centred, responsive proactive care.

Evidence provided includes the implementation plan of the new policy and guidance including awareness training sessions, enhanced skills training and available online training modules. A short life working group was also commenced in August 2025 to review all care plans in relation to continuous interventions and person centred care planning. New documentation includes the multidisciplinary team continuous intervention person centred care plan, continuous intervention designated staff comments and review log, and continuous intervention chart for the electronic patient care records. The continuous intervention person centred care plan enables staff to document reason for continuous interventions such as violence and aggression, disinhibition and self-harm.

The care plan has an area to document proximity of required intervention for various activities including use of bathroom, if in a public area (including school), time in own room and sleeping. Proximity required is specified as within arm's length, verbal prompt and check and within site. The care plan also has a section to document identified need, person centred goals and family and carers views as well as a table to tick if the care plan has been discussed with family and carers and the patient and an area to document the reason if not discussed. The continuous intervention log is a table where the designated member of staff undertaking continuous interventions is recorded along with an area to document activity, significant changes or concerns. There is also an area

to document the continuous intervention 24 hour review including who was involved, designation and outcome.

Evidence provided includes child and adolescent mental health specific suggested activities for staff to implement if a young person is on continuous interventions. These include decider skills, leisure activities, creative activities and self-care activities such as relaxation and sleep hygiene. Decider skills are a set of skills designed to help young people manage difficult emotions and/or impulsive behaviour such as self-harm. We were also provided with the patient and family continuous intervention information leaflet. This explains that continuous intervention is designed to provide person centred supportive and therapeutic engagement. It also documents the use of wellness toolkits which can be used independently or with staff support, these include fidget items and stress balls, sketchpads and notebooks and board and card games. Staff told inspectors of the availability and use of distraction boxes for young people which included such things as fidget spinners, notebooks, pencils and slime. We were also advised that the use of these would be risk assessed and tailored for each young person.

There were several young people receiving continuous interventions throughout our onsite inspection and we observed that these were adjusted during family visits to allow for privacy whilst also ensuring risk was minimised. We were able to review a small number of continuous intervention care plans during our inspection which were up to date, appeared complete with risk identified clearly and reviewed daily.

Seclusion

We can see that approximately five percent of incident reports completed in the six months prior to our inspection relate to the use of seclusion. The Mental Welfare Commission use of seclusion good practice guide documents that it should only be considered when the person is a significant danger to others and the situation cannot be managed by any other means. Staff told inspectors that NHS Greater Glasgow and Clyde do not currently have a board wide seclusion policy. However, Skye House utilises local seclusion guidance. Within this it states the decision to implement seclusion can only be made by medical staff or the nurse in charge and should be implemented for the shortest time possible.

The Skye House seclusion guidance documents two types of seclusion: Level 1 where a young person is secluded within a room alone. Level 2 seclusion includes when staff remain with the young person whilst they are secluded or place restrictions on the young person's physical environment with the intention to keep them separate from others. It is also highlighted that the guidance has been adapted from the Mental Welfare Commission use of seclusion good practice guide. Inspectors observed that the use of seclusion for one young person including duration was discussed at the Skye House business meeting on the second day of our inspection. We were advised by senior managers that a short life working group is currently developing an NHS Greater Glasgow and Clyde seclusion policy. We can also see that the level and duration of seclusion is not always documented in submitted incident reports. However, this may have been documented in the young person's care records.

Physical health care

During our onsite inspection we were told about the mental health physical health nurse role. Evidence provided includes the job summary for the role which describes it as a key role in ensuring the physical health of young people are identified including supporting early intervention and health promotion. Key responsibilities include managing and coordinating physical health monitoring, promoting healthy lifestyles such as smoking cessation and wound care. Senior managers told us the physical health nurse has worked in collaboration with the tissue viability team to develop a new tool for staff in relation to wound treatment, we also observed this documented in evidence provided.

NHS Greater Glasgow and Clyde Mental Health Services Mandatory Training Medical Emergency Training Standard Operating Procedure documents that medical emergency training is a mandatory requirement for all frontline staff working in inpatient services. We asked how young people's physical health was reviewed if required out of hours and in an emergency and were advised there is 24 hour medical provision via the psychiatry on call rota. We can also see in incident reports submitted as evidence that in the case of a medical emergency staff can call 2222 for a medical emergency response. This number can also be called for a mental health emergency response such as assistance with violence and aggression. The 2222 number is a dedicated emergency number used in hospitals which connects to the switchboard who then activates an emergency response team.

We were also advised that all medical staff and registered nursing staff complete adolescent medical emergency training. NHS Greater Glasgow and Clyde utilise 'cascade' training to support timely access and completion of training. Registered staff who have successfully completed medical emergency training and deemed as proficient are identified and nominated to complete further training to become cascade trainers. Cascade trainers are supported by the resuscitation officer and practice development nurse to facilitate a local training programme. We can see in evidence provided that training compliance for medical emergency training for Skye House staff is good with the majority of staff having completed training in the past 12 months and training updates booked for those staff whose training is due to lapse.

Learning outcomes for medical emergency training course includes demonstration and application of the ABCDE approach and national early warning score 2 (NEWS2) scoring, treatment and recognition of anaphylaxes, safe use of automated external defibrillator, overview of emergency pharmacology and basic airway management. The national early warning score 2 and paediatric early warning score (PEWS) are systems that measure physiological parameters such as heart rate and respiratory rate to improve the detection and response to people who are at risk or have become more unwell. The ABCDE approach is a systematic method used in healthcare to assess physically deteriorating or critically ill patients.

Evidence provided includes details of the NHS Greater Glasgow and Clyde mental health inpatients adolescent medical emergency training presentation which was developed by the resuscitation leads for NHS Greater Glasgow and Clyde. This includes the escalation

process and actions to be taken dependant on a young person's paediatric early warning score. Escalation actions vary depending on score from repeating observations in 60 mins for a score of 1-2 to calling 2222 for an immediate response for a score of five or more. Inspectors did not have the opportunity to review any paediatric early warning score charts during our onsite inspection.

Documentation

As previously discussed, we were able to review a small number of patient care records during our onsite inspection. We observed that some care plans were comprehensive and clearly evidenced the young person's participation and discussion around their care needs. We observed evidence of person-centred care planning including information for staff on how to communicate to support the young person if they were experiencing stress and distress. However, whilst we observed that initial risk specific risk assessments were completed it was unclear how risk was mitigated if identified. This included one pressure ulcer risk assessment which identified the young person being at high risk of developing pressure ulcers. However, a specific care plan to mitigate risk was not in place.

NHS Greater Glasgow and Clyde utilise a mental health combined care assurance tool to audit aspects of care including patient care documentation and person centred care. Senior managers advised that these include self-audit and peer review audits. A peer review audit is completed by staff from other areas to ensure transparency and objectivity. We were provided with the completed audit for Skye House from March 2025 which has an overall audit score of 76%. The lowest scoring section at 61% is for initial assessments to 'identify underlying health needs/risk/conditions to inform appropriate and effective care'. This includes a score of 33% for nutritional screening within 24 hours of admission. We can also see that it is highlighted in another section that only 50% of young people had a physical health care plan initiated or reviewed within 24 hours of admission.

The combined care assurance tool for March also documents that out of two young people asked both replied no when asked if they are involved in the planning of their care. We can also see that there is an overall score of 72% for the section relating to "appropriate ongoing assessment of care needs documented throughout this admission". This includes 6/6 records not having evidence that care plans have been reviewed on planned dates where appropriate. Senior managers advised that a short life working group including members of the multidisciplinary team was commenced in August 2025 to review care planning and that young people and their families/carers views will be sought.

The combined care assurance tool also documents that there was no system in place to confirm young people's identity including date of birth if they were unable to do so themselves. During our inspection of the National Child Psychiatry Inpatient Unit (NHS Greater Glasgow and Clyde) staff told us that there was a picture of each young person on their electronic drug prescription chart to enable staff to identify young people if they are unable to confirm their name and date of birth. We were also advised that this would be discussed with the young person and their family/carers and that there is a

consent form for them to complete. Senior managers were aware of this and advised they would consider implementing the same process for Skye House.

Whilst we recognise NHS Greater Glasgow and Clyde have started a review of care plan documentation a requirement has been given to support improvement in this area.

Care environment and infection control and prevention

Standard infection control precautions such as linen, waste and sharps management and maintenance of the care environment minimise the risk of cross infection and must be consistently practiced by all staff. Skye House has a laundry room including washing machines for young people's personal clothing and used linen skips for hospital linen such as bedding. Inspectors observed a bag of used linen placed on top of a linen skip which had clean sheets stored underneath. This is not in line with the National Infection Prevention Control Manual which documents that clean linen should be stored separately from used linen. A requirement has been given to support improvement in this area.

Hand hygiene is an importance practice in reducing the transmission of infection. The national infection prevention control manual documents that effective hand hygiene requires staff to be bare below the elbows. This means that staff should have their forearms and hands uncovered to enable effective hand hygiene. Inspectors observed that several staff were not bare below the elbow including wearing watches and wrist bands. A requirement has been given to support improvement in this area.

We were able to speak with domestic staff during our inspection who advised they were provided with adequate cleaning supplies. They described difficulties in some instances in accessing young people's rooms to clean at times due to young people being in their rooms. However, if unable to clean a room they would escalate this to the domestic supervisor and nursing staff. Domestics we spoke with told us they enjoyed working at Skye House and felt supported by the team. They also advised that nursing staff would hand over to them any rooms that should not be cleaned each day.

Skye House windows include a metal mesh on the inside of one side of the windows to enable them to be opened whilst reducing ligature risk and the risk of absconding. Whilst we observed that the majority of the environment was clean and well maintained we observed that the window meshes had dirt in them. However, when we raised this with senior managers at the time of inspection it was not clear who was responsible for cleaning them. We asked for an update on this and senior managers advised the windows were installed as part of the reduced ligature work at Skye House and other areas on the Stobhill Campus. Discussion is currently ongoing to develop a maintenance process for a cleaning schedule. A requirement has been given to support improvement in this area.

During our onsite inspection staff told us that there had been ongoing issues with the heating in Skye House and that the unit was too hot. We also observed a small number of incident reports submitted in relation to the heat within the unit. Staff advised that this had been an ongoing issue and although reported to maintenance that the unit still remained too hot. We were also advised that one of the rooms was currently not in use

due to the heat. Inspectors also observed that the whole unit felt very hot including all three wings, treatment rooms and staff rooms.

On the first day of our inspection, we observed that the medication fridge in one of the treatment rooms had been placed next to the chair used for young people receiving nutrition via nasogastric tube causing an obstruction for staff if utilising safe holds. Staff advised that this was due to the fridge becoming hot whilst under the work surface. We raised this with senior managers at the time of inspection, and we observed that this had been rectified on the second day of inspection.

Medicines should be stored at the correct temperature to maintain their quality, effectiveness and safety. Staff advised inspectors that the treatment room temperatures are monitored and that no medication had been required to be moved or destroyed due to the heat.

We discussed the heating and high temperature with a member of the NHS Greater Glasgow and Clyde estates team who advised it may be due to a fault in the under floor heating and that this was due to be assessed. We asked senior managers for an update on the heating during one of our virtual discussions who advised that a specialist contractor had been to review the system and that there had been some improvement. However, due to ongoing heat in the treatment rooms extraction and ventilation systems were being considered. We were also advised that a monthly meeting with members of the estates and facilities team had also been implemented which included a recent walk around of the unit to identify any issues and that a regular maintenance contract is being explored. A requirement has been given to support improvement in this area.

Dignity and respect

During our onsite inspection we observed, positive, respectful and responsive interactions between staff and young people. However, inspectors observed large gaps around some toilet doors which could have an impact on privacy and dignity.

We observed that there was available information for young people throughout Skye House in the form of leaflets and posters. This included information relating to the mental health act, advocacy services and Skye House school.

Staff told inspectors that each young person's care is reviewed at scheduled fortnightly multidisciplinary team meetings. Key members of staff at these meetings include the young persons responsible medical officer, allied health professionals, psychologist and care manager. Part of the care managers role is to liaise with the young person and their carers/families after these meeting to discuss any updates. We were also told that the care manager can share any information from families/carers at these meetings. Staff also told us that young people have fortnightly 1:1 meetings with their named nurse. NHS Greater Glasgow and Clyde named nurse guidance role and responsibilities documents that the named nurse is responsible for ensuring the application of the nursing process including assessing and reviewing the effectiveness of nursing care, including the development of person centred care plans.

All young people are offered a fortnightly young person's meeting which enables young people to provide feedback and ask questions such as those about their care plan, medication or passes home. If a young person does not wish to attend in person opportunity is provided for them to submit any comments or questions in writing. The meetings are attended by members of the multidisciplinary team including psychiatry care manager and nursing staff. We can see in evidence provided that feedback has been sought from young people in relation to these meetings. Comments from young people include that they like having a meeting which is just for them and like having a written record of the meeting including if they did not attend. However, they also highlighted that they felt there are too many people in the room and did not like staff being behind laptops although understood someone needed to take notes. We asked senior managers if any changes have been implemented in relation to the feedback who advised that this will be discussed at the Skye House operational management group at the end of October. However, we were also told that after feedback from young people the meeting is attended by a maximum of four members of the multidisciplinary team.

Incidents reported in the six months prior to our inspection included 10 where staff were required to intervene to prevent young people from assaulting or attempting to assault another young person. Documented actions in the incident reports include the involvement of the police where required or if requested by the young person, discussion with public protection services, change of ward areas so the young people involved could be kept separate and the use of continuous interventions. We can also see that it is documented when the young person's family were notified. Senior managers advised any matters relating to allegations made by young people including that of other young people or staff is treated as a public protection matter and the public protection protocol will be mandated. We can also see in further evidence provided that one young person had been discharged and a risk management plan has been developed to mitigate any potential risk should the young person be readmitted.

Staff we spoke with told us that mobile phone access is restricted for young people. It is also documented in the Skye House Information for Young People and their carers booklet that whilst mobile phones can be brought into the unit access will be restricted until the hours of 1600-1700 and 1800-2100. It is also documented that videos and voice recordings are not to be taken of other young people or staff to maintain privacy. It is also explained that Skye House has an open visiting policy and available electronic tablets that can be utilised for virtual calls.

The Mental Health (Care and Treatment) (Scotland) Act 2003 enables patients in mental health units to be designated a 'specified person' if their responsible medical officer has a reasoned opinion that either their own health, safety, or welfare of others is at risk as noted earlier in this report. Senior managers advised that specified persons process can be utilised if a young person is assessed as being at risk when using a mobile device.

Evidence provided includes the Skye House mobile device local protocol – information for staff, young people and their carers. This specifies that mobile devices include any device capable of to record sound or pictures and connect to the internet. The protocol describes need to balance the right to use mobile devices within the unit whilst maintaining a duty of care to protect the safety and privacy and dignity of young people

at all times. It is also highlighted that the privacy and dignity of staff should also be protected and no information about staff should be shared on social media. It is explained that mobile devices are not available during therapeutic and educational session. It is also documented that restrictions on mobile devices are applicable to staff and that staff are not to use or carry their personal phones whilst on duty and undertaking clinical activity.

During our onsite inspection staff including senior managers discussed the challenges in balancing the therapeutic and rights to use mobile devices whilst protecting young people and staff privacy and dignity. We were advised that the unit has available electronic tablets that can be used by young people including for virtual meetings with families/carers. we were also told that the mobile device policy is discussed with families/carers and in some cases, families have provided more basic devices that do not have the facility to record.

Staff told inspectors that there have been episodes where young people have recorded other young people or staff including an episode where a young person uploaded a video online to a social media platform. We can see in evidence provided relating to this that the police and public protection have been notified of the incident. We asked senior managers what had been put in place to support young people in relation to this who advised the occupational therapy team have recently supported the advocacy team to arrange individual and group sessions with young people to discuss the safe use of social media. We were also advised that the mobile device policy is often raised by young people at the community meeting and discussions held regarding online safety.

We received the Quality Network for Inpatient CAMHS (QNIC) focused review report and action plan for Skye House (November 2024) relating to the Royal College of Psychiatry network for inpatient child and adolescent standards. We can see from the report that it is documented that young people and visitors do not have access to alarms to call for help. We can see it is documented in the action plan that mitigation for this includes 15 minute staff walk arounds and completion of risk assessments prior to visiting taking place.

The doors to Skye House are locked and there is a main reception which is staffed from 0900-1700, Monday to Friday which is accessed via a buzzer call system. Staff advised that out with these times the buzzer will be answered by staff within the inpatient's unit. A patients access and egress to and from hospital units may be restricted if there is a risk of harm to the patient or others. For example, if a patient is unable to maintain their own safety and at risk of absconding or is at risk of harming or being harmed by others.

Senior managers advised that the NHS Greater Glasgow and Clyde mental health services policy for locking doors on open wards was updated in October 2025. It is documented in this that staff are required to consider the balance between patient's wishes and duty of care without putting patients at unnecessary risks. It also discusses the rights of other patients who have no restrictions in place if doors are to be locked and that they should have available information provided in relation to locked doors. It is documented in the Skye House information booklet for young people and carers that

the front doors to the unit are locked and that nursing staff will assist if a young person or their family/carers wish to enter or exit the unit. We were told by senior managers that the main entrance door to the unit remains closed at all times to prevent unauthorised access. If a young person is not detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, staff ensure that they are able to leave the unit if they wish to.

During our onsite inspection we observed that one of the doors to the wings was locked and staff told inspectors that this was enacted to maintain safety and therefore the locked door policy had been enacted. It is documented in the locked door policy that signage must be placed on both sides of the door explaining that the door has been locked and instructions provided on how to enter and exit and a door locking form must be completed. We did not see any signs on the doors to the inpatient unit or the wing that was locked during our onsite inspection. A requirement has been given to support improvement in this area.

Mixed sex accommodation can have an impact on dignity and personal choice. Whilst Skye House does not have any gender specific communal areas all young people have individual bedrooms including en-suite bathrooms to enable privacy. There is also a lounge area in each wing as well as a consultation room.

We observed that there were gaps around some of the toilet doors particularly in the young person's toilet in the school building. We were told by one member of staff that this gap could be used to ascertain if young people were safe if there was no response from them when they were in the toilet. However, the gap was significant and would enable a full view of anyone who was actually using the toilet at the time. We raised this with senior managers who advised during the second day of our inspection that the doors were being reviewed by the estates department. A requirement has been given to support improvement in this area.

We were provided with NHS Greater Glasgow and Clyde's sexual safety policy which has been developed in accordance with the Sexual Safety Collaborative (SSC's) standards and guidance, which was developed by the Royal College of Psychiatrists to improve sexual safety in mental health, learning disability and autism inpatient settings. This is in draft form and awaiting ratification with an anticipated finalisation date of April 2026.

Summary of joint findings by the Mental Welfare Commission and Healthcare Improvement Scotland.

Areas of Good Practice

1. Introduction of the care manager role to coordinate young people's care and be key point of contact for young people's carers and families.
2. Availability of an indoor gymnasium and outdoor multi use games area.
3. Provision of additional funding to significantly increase the nursing establishment and also review and increase the multidisciplinary team.
4. Provision of additional senior nursing support.

5. Availability of regular reflective practice and debrief sessions for staff.
6. The introduction of a number of short life working groups as part of improvement initiatives.
7. Fortnightly community meetings for young people and staff.
8. Introduction of a new carers' support group.
9. Implementation of new NHS Greater Glasgow and Clyde continuous intervention guidance and person centred care plan.
10. Introduction of the mental health physical health nurse role.
11. Medication and cleaning products were stored securely.

Areas for improvement

1. Culture: significant concerns were raised in relation to the attitudes of some staff, both permanent and supplementary. This was reported to Skye House managers at the time of our visit and action taken that should ensure that there is ongoing investment in culture change. This includes supporting colleagues who witness and hear such attitudes to not tolerate but to address this behaviour directly with their peers/line managers.
2. There are long standing gaps in staffing at Skye House. Whilst the recent reported commitment to increase nurse staffing levels at Skye House is welcome, implementation and impact underpinned by a robust workforce model is required (see requirement noted below).
3. Authority to treat young people should be in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003. Lawful practice and understanding of roles and responsibilities has yet to be embedded at Skye House. There is a need to implement a robust system of audit involving the multidisciplinary team.
4. NHS Greater Glasgow and Clyde should consider adding self-harm and suicide prevention training to mandatory training for Skye House staff.
5. Restraint recording requires to be consistent in terms of numbers and detail. Multiple restraints need to be recorded as such to avoid under-reporting.
6. Social work vacancy: this vacancy requires to be filled and there needs to be understanding of the value of the social work contribution. This will also enhance understanding of child and adult support and protection practice and reporting.
7. The quality of care plans and risk assessments/risk management plans need to improve and be subject to regular audit. (linked to requirement noted below).
8. An NHS Greater Glasgow and Clyde seclusion policy needs to be in place to underpin the use of seclusion at Skye House.
9. Anyone has a right to make an advance statement, and we recommend that Skye House build the offer of an advance statement into practice when the person is well, as part of discharge planning.

Requirements

The following requirements have been made which NHS Greater Glasgow and Clyde must

prioritise to meet national standards.

- **NHS Greater Glasgow and Clyde must ensure that all staff are aware of their responsibilities in relation to child protection and adult support and protection and safeguarding policy and legislation is followed when there is evidence of harm and/or immediate risk (see page 33).**

  This will support compliance with: NHS Public Protection Accountability and Assurance Framework (2022) and Quality Assurance System: Quality Assurance Framework, criteria 2.2,2.3, 2.4, 2.5 and 2.6.

- **NHS Greater Glasgow and Clyde must ensure all improvement actions within fire risk assessments are completed, fire safety equipment is tested and maintained within required timeframes and staff are trained in fire evacuation procedures (see page 34).**

  This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).

- **NHS Greater Glasgow and Clyde must ensure that a robust multidisciplinary workforce model is implemented to promote patient and staff safety (see pages 28 and 35).**

  This will support compliance with: Health and Care (Staffing) (Scotland) Act (2019) and Quality Assurance System: Quality Assurance Framework, criteria 2.2, 2.3, 2.6, 4.3, 6.1 and 6.5.

- **NHS Greater Glasgow and Clyde must ensure clinical leaders are provided with adequate time to lead and ensure the timely completion of staff appraisals (see page 38).**

  This will support compliance with: the Health and Care (Staffing) (Scotland) Act (2019), The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2018) and relevant codes of practice of regulated healthcare professions.

- **NHS Greater Glasgow and Clyde must enable staff to be supported to attend clinical supervision and reflective practice (see page 42).**

  This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022), criterion 4.4, the Health and Care (Staffing) (Scotland) Act (2019), The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2018) and relevant codes of practice of regulated healthcare professions.

- **NHS Greater Glasgow and Clyde must ensure timely review and implementation of lessons learned from reported incidents including significant adverse events**

(see page 43).

This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.5, 2.6, 4.1, 6.1, 6.7, 7.3 and the National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (2025).

- **NHS Greater Glasgow and Clyde must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use (see page 44).**

  This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criterion 2.5 and 2.6.

- **NHS Greater Glasgow and Clyde must ensure meaningful activity is consistently provided, including evenings and weekends (see pages 22 and 48).**

  This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.2, 6.1, 6.2, 6.6 and Health and Social Care Standards (2017) criteria 2.21 and 2.22.

- **NHS Greater Glasgow and Clyde must ensure adequate provision of mealtime support, therapeutic environment during mealtimes and a full range of dietary options (see page 54).**

  This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.2, 6.1, 6.5 and Health and Social Care Standards (2017) criterion 1.33 and 1.37.

- **NHS Greater Glasgow and Clyde must ensure robust processes are in place to provide adequate dietetic cover (see page 55).**

  This will support compliance with: Quality Assurance Framework (2022) criteria 4.1 and 6.1

- **NHS Greater Glasgow and Clyde must ensure that:**

  ***all young person's care documentation is accurately and consistently completed and reviewed appropriately**

  ***young people and their families are involved in planning their care, and that this is clearly documented**

  ***there is a system in place to identify young people if they are unable to confirm their name and date of birth themselves during medication administration (see pages 8 and 58).**

  This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.2, 6.1, 6.2, 6.6 and Health and Social Care Standards (2017) 2,21 and 2.22.

- **NHS Greater Glasgow and Clyde must ensure all staff are compliant with the safe management of linen and appropriate wearing of jewellery (see page 63).**

  This will support compliance with: The National Infection Prevention and Control Manual criteria 1.2, 1.7 and NHS Scotland National Uniform Policy, Dress Code and Laundering Policy 2018.

- **NHS Greater Glasgow and Clyde must ensure adequate oversight and cleaning schedules for windows including window mesh (see page 63).**

  This will support compliance with: The National Infection Prevention and Control Manual criteria 1.6.

- **NHS Greater Glasgow and Clyde must ensure measures are put in place to ensure regular maintenance and timely repair of heating systems (see pages 25 and 64).**

  This will support compliance with: Health and Social Care Standards 2017 criterion 5.

- **NHS Greater Glasgow and Clyde must ensure there is clear signage in place when entry and exits to wards are locked as per NHS Greater Glasgow and Clyde policy (see page 67).**

  This will support compliance with: Quality Assurance Framework (2022), Health & Social Care Standards 2017.

- **NHS Greater Glasgow and Clyde must ensure the Skye House building environment, including visiting areas, is monitored and maintained including to promote privacy and dignity (see page 67).**

  This will support compliance with: Health and Social Care Standards (2017) criteria 4.11, 5.2, 5.3 and 5.4; Quality Assurance System: Quality Assurance Framework (2022) Criteria 6.2; Health and Social Care Standards (2017) Criterion 1.23.

Next Steps

A requirement in the visit/inspection report means the hospital or service has not met the required standards and that we are concerned about the impact this has on patients using the hospital or service. A recommendation relates to best practice which the NHS board should follow to deliver on patients' rights and improve their experience of and standards of care.

We expect NHS Greater Glasgow and Clyde to address all of the requirements and areas for improvement. The NHS board must prioritise the requirements to meet national standards.

An improvement action plan has been developed by the NHS board and is available on both the Healthcare Improvement Scotland website: http://www.healthcareimprovementscotland.scot/ and the Mental Welfare Commission website: https://www.mwcscot.org.uk/.

We are grateful to all those who took the time to engage with us as part of this joint visit/investigation process undertaken by the Commission and Healthcare Improvement Scotland.

Appendix A:

The role of the Mental Welfare Commission and Healthcare Improvement Scotland

The Commission is an independent organisation originally established by the Mental Health (Scotland) Act 1960. It is uniquely placed to safeguard the rights and welfare of individuals with a learning disability, mental illness, dementia or related condition.

The Commission is also a corporate parent under the Children and Young People (Scotland) Act 2014, with duties conferred to promote and protect the welfare of care experienced children and young people. The rights of the child were further expanded through the United Nations Convention on the Rights of the Child (Incorporation)(Scotland) Act 2024 and therefore, as a listed authority, the Commission is also duty bound to act and report in compliance with this legislation and incorporated UNCRC articles.

Mental Welfare Commission

Our focus is on individuals and their experience of care and treatment. We make sure that the care and treatment of a person with a mental health condition (children, young people and adults) is in line with the principles of both the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA 2003) and the Adults with Incapacity (Scotland) Act 2000 (AWIA 2000).

Section 13 of the MHA 2003 describes the visits that the Commission is authorised to undertake. Our engagement and participation officers, mental health nurses, social workers (mental health officers) and psychiatrists visit and speak to people who use services, their carers, their families, their advocacy supporters and their mental health officers so that we can understand what their experience of care is like. We aim to identify both good experiences but also areas of care, treatment and law which are not respecting the rights of the person being cared for. We also review care records and speak with staff and managers to understand what they are doing to provide the highest quality care, treatment and support according to mental health and incapacity legislation.

Healthcare Improvement Scotland

The role of Healthcare Improvement Scotland is to support, ensure and monitor the quality of healthcare in Scotland by providing objective and independent quality assurance of healthcare services provided in Scotland.

The organisations core purpose is to enable the people of Scotland to experience the best quality health and social care, with a specific focus on safety. It is part of Healthcare Improvement Scotland's Safe Delivery of Care Inspection Methodology to review systems, culture, leadership and governance of areas inspected.

The statutory duties for Healthcare Improvement Scotland are set out in the Public Services Reform Act (Scotland) 2010 and the National Health Service (Scotland) Act 1978.

Healthcare Improvement Scotland has adapted the safe delivery of care inspection methodology to minimise the impact of inspections on both the young people receiving care and the staff delivering that care. Our inspection teams carried out as much of their

inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We aimed to keep discussion with clinical staff to a minimum and reduce the time spent looking at care records to avoid duplication of work undertaken by the Commission.

Appendix B – List of References

The following references to national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

1. NHS Scotland CAMHS Model (2).pdf
2. https://www.gov.scot/Publications/2018/08/8292
3. InvestigationIntoTheCareAndTreatmentOfMrD_2023.pdf
4. Carers, consent, and confidentiality
5. https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/pages/3
6. Principles and Standards for Independent Advocacy Reflecting Commissioners' Statutory Responsibility - Independent advocacy: guide for commissioners - gov.scot
7. SocialCircumstancesReports_GoodPracticeGuide_2022_1.pdf
8. https://www.gov.scot/publications/national-standards-mental-health-officer-services/
9. https://www.nice.org.uk/guidance/ng10
10. Rights, risks and limits to freedom
11. https://www.nsc.org/getmedia/a291988d-7fc6-4fbc-98f3-76ac5f7f0570/patient-restraints-english.pdf.aspx
12. Naso-Gastric-Tube-feeding-under-restraint.pdf
13. MedicalTreatmentUnderPart16MHA_2021_0.pdf
14. Specified persons good practice guide
15. Carers, consent, and confidentiality
16. looking_after_your_rights_leaflet__high_res_.pdf

Appendix C - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

1. Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, January 2016)
2. Covert Medication (Mental Welfare Commission, May 2022)
3. Food Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
4. Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
5. GIRFEC principles and values - Getting it right for every child (GIRFEC)
6. Health and Care (Staffing) (Scotland) Act (Scottish Government, 2019)
7. Health and Social Care Standards (Scottish Government, June 2017)
8. Infection Prevention and Control Standards (Healthcare Improvement Scotland, 2022)
9. Mental Health (Care and Treatment) (Scotland) Act 2003 (Scottish Government, 2003)
10. Mental Health Scotland Act 2015 (Scottish Government, 2015)
11. National Infection Prevention and Control Manual (NHS National Services Scotland, June 2023)
12. National child protection guidance – Child Protection (Scottish Government, 2023)
13. NMC Record keeping: Guidance for nurses and midwives (Nursing & Midwifery Council, August 2012)
14. Operating Framework: Healthcare Improvement Scotland and Scottish Government (Healthcare Improvement Scotland, November 2022)
15. Person Centred Care Plans (Mental Welfare Commission, August 2019)
16. Person-centred care (Nursing & Midwifery Council, December 2020)
17. Preparation of care plans for people subject to compulsory care and treatment (Mental Welfare Commission, October 2021)

18. Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)

19. Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)

20. Rights, risks, and limits to freedom (Mental Welfare Commission, March 2021)

21. Scottish Patient Safety Programme SPSP (Healthcare ImprovementScotland)

22. The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)

23. The Quality Assurance System (Healthcare Improvement Scotland, September 2022)

24. The UNCRC Act - UNCRC (Incorporation) (Scotland) Act 2024) (Scottish Government, February 2024)