Mental Welfare Commission for Scotland

Report on unannounced visit to:
Kylepark Cottage Assessment and Treatment Unit, Kirklands Hospital, Fallside Road, Bothwell G71 8BB

Date of visit: 13 June 2025

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

Where we visited

Kylepark Cottage assessment and treatment unit is situated in Kirklands Hospital. It is a purpose-built, mixed-sex facility with nine assessment and treatment beds and three low secure beds for adults with a learning disability. There was also a specific area which could provide care for one person with complex needs.

On the day of our visit there were nine individuals in the unit.

We last visited this service in May 2023 on an announced visit and made one recommendation that an audit system be put in place to ensure that all medication prescribed under the mental health or incapacity legislation are properly authorised.

On this unannounced visit, we wanted to follow up on the previous recommendation, meet with individuals, relatives/carers and staff to hear their views and experiences on how care and treatment was provided on the unit.

Who we met with

We met with five people and reviewed the care records of four of them. We also reviewed another person's care records.

We spoke with four relatives, three of whom we met in person, and another relative who we spoke with on the telephone.

We spoke with the service manager (SM), the acting senior charge nurse (SCN), the senior nurse (SN) and nursing staff.

Commission visitors

Sandra Rae, social work officer

Gordon Mc Nellis, nursing officer

What people told us and what we found

Feedback from individuals and relatives was mostly positive about Kylepark assessment and treatment unit.

Individuals told us about the staff in the unit were “good”, that they “help with anything I need”, that nurses were “helpful” and “helped me to move on” and staff “take me out to places I like.” Another person said that the whole staff team “care about me getting the right house and care when I leave, and help me prepare for this, as I am scared”. Others said “the staff listen to me” and for some, they told us “I love the cooking classes with OT” and “going out to fitness classes is ace”. We also heard “the doctor speaks to you and your family about a plan to get well.”

We heard from an individual that “staff take us shopping and to other things in the area, out of hospital.” We heard from one person that staff were helping them plan for having their own house and taking them shopping to places where they could buy things so they could get an idea of what was available.

We heard mixed views in relation to the food; for some it was “good”, however we also heard “it was boring and the same, all the time.”

We heard from families and carers who were mainly complimentary of the whole staff team. We heard that “staff are supportive”, that “communication is great and I feel fully involved in the care plan for my child”, that “staff treat my family member with respect and take time to listen to them and me”, that “care is excellent and staff are always positive even when they are challenged by my family member”, that “I know my relative receives good care and they tell me how staff work with them consistently, which is helpful, as I feel guilty leaving them” and “they listen to my views and invite the welfare guardian to attend meetings as well”.

A relative told us that they “couldn’t fault the whole team” and “the team recognise me as a carer and the stresses I feel and worry about discharge and getting the right support.” One family member said that for their young person, timescales for assessments by others, like social work, can take a while. They informed us that getting care can mean a hospital discharge delay, which is not helpful and has a negative impact on the individual, but it is important the right services are in place for discharge. One relative told us communication in the unit could, at times, be better at times.

We heard from staff that they enjoyed working in Kylepark; some staff had worked in the unit since qualifying a few years earlier and informed us they were really satisfied working in the unit, with a great staff team. We also heard comments from staff that “the management team also ensure we are supported, and our views are asked for and fully considered when making decisions”. We were of the view this was

necessary due to the level of input required from staff working with high levels of mental acuity and the complex levels of stress and distress of the people on the unit.

Care, treatment, support, and participation

Care records

Information on individuals' care and treatment had been previously held on a paper file. There had been a very recent transfer to the electronic recording system, MORSE. This was a challenging time for the staff trying to navigate both systems. We discussed with the management team at the end of our visit and were reassured that a robust audit system was being put in place, initially for a six-month period. This was to ensure that all the relevant information was transferred onto MORSE and to support staff to complete this process and aide confidence when working with one system.

The care records were of a good standard and linked with care plans and risk assessments and found the paper notes easy to navigate.

The recordings documented by staff could have been more explicit. An example of this was that we noted nurses delivering ongoing one-to-one support, however, these did not explicitly highlight the frequency and detail of the engagement with the one-to-one interactions that took place; the recordings were documented in general care records. The management team recognised the level of this support provided by nursing staff and advised us that they were supporting staff to be more explicit and record as one-to-one interactions.

We found comprehensive admission assessments that included the individual and family views, where relevant and all individual records contained a physical assessment.

Care plans

We saw excellent examples of care plans that were person-centred that were robust and had a strengths-based approach.

There was a wide range of care plans that were individualised and included the work happening with a variety of disciplines. These gave a good insight into the individual and the range of care for their mental health, physical health, and each person's wellbeing.

The physical needs of each person were assessed at admission and annual physical health checks were completed. We were informed if the person's physical health changed at any time this would be addressed through ongoing review. The care plans, risk assessments and risk management plans were all linked to both mental and physical health, were detailed and linked with the level of risk that some medications to treat mental health could have on physical wellbeing.

Delayed discharge

Delayed discharge is a term used when a person is medically fit to leave hospital but are unable to leave due to non-medical factors. This usually means there is a lack of appropriate care or services available, such as a lack of available care home placement or difficulties coordinating care. It can also be the result of there being no legal proxy in place when needed to support the person move from hospital to care as they do not wish to go to a care facility.

During our visit there were four people who were recorded as being a delayed discharge. Some people were waiting for a care package to be put in place, and we heard there were recruitment issues around community support providers. We were advised that finding suitable housing was also being a barrier to discharge.

For some, the guardianship application process delayed discharge. The unit and the service manager were actively highlighting the delays and barriers to discharge using the Dynamic Support Register, to ensure delayed discharges were recorded appropriately and discussed with relevant others to help progress discharge and maintains discussions around this. The register was developed and implemented as a result of the 'Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge' (www.gov.scot); its purpose is to avoid people with learning disabilities living in hospitals, or in out-of-area placements which they and their family have not chosen. It has been designed to help professionals collaborate with people with learning disabilities to better respond to situations where there is a need for a more intensive level of care management.

Multidisciplinary team (MDT)

The unit had a range of professionals who contributed to the individuals' care and treatment. The MDT consists of nursing staff, psychiatrist, psychology, occupational therapy staff (OT) and pharmacy. Referrals were made to all other services as and when needed.

It was clear from the MDT when the person was moving towards discharge as the relevant community services also attend the MDT meetings.

We saw that the multidisciplinary team (MDT) were fully involved in developing the care and treatment plans that supported an integrated approach to care and we were pleased to see the individual's participation was reflected in care plans. We also saw the person's relatives/carers had input into care and treatment plans, with information from them and their views recorded. This aligns with the Triangle of Care work the unit have been taking forward to ensure that individuals, their families and legal proxies are involved in and have contributed to the individuals' care journey.

We were informed of ongoing audits of care plans, with improvement actions discussed during supervision and then shared across the team, supporting ongoing improvement in robust care planning for each person's wellbeing.

We were pleased to see that the unit had considered adult support and protection legislation and made referrals to social work effectively which were followed up in a joint and person-centred way.

MDT minutes were recorded appropriately, and we heard that going forward, MDT minutes would be uploaded to MORSE using a generic template that provided a record detailing actions and a review of these. We found that the current review notes had a good level of detail. The OT and speech and language therapy (SALT) recordings were informative and gave an overview of input; we found the psychology notes were less comprehensive. We spoke with nursing staff on the day of our visit, and they were unable to access or provide us with any more in-depth psychology notes within the unit.

Recommendation 1:
Managers should ensure all relevant psychology notes are available to all other professionals involved in providing the person's care within the unit.

We asked the management team if there were any staffing challenges in the unit and they advised us that there were nursing vacancies that they were actively looking to recruit to, with experienced qualified nursing staff to complement the staff team and support the level of need of the individuals in this specialist unit. There was an advertisement for experienced, permanent nursing staff on the recruitment portal when we visited the unit.

Use of mental health and incapacity legislation

On the day of our visit, nine people in the unit were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 ('the Mental Health Act'). We found the documentation that related to the individuals' legal status in order and easily accessible.

We discussed the uploading of this paperwork on to the new MORSE system and were informed that a group had been set up to look at how this would be progressed as there were some issues with the system's capacity; the management team from the unit were actively involved in this.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) should correspond to the medication being prescribed. All documentation relating to the Mental Health Act around capacity to consent to

treatment was in place and completed appropriately. We were pleased to see that our earlier recommendation had been actioned and that an audit system had been put in place to ensure that all medication prescribed under the Mental Health Act, or incapacity legislation, was properly authorised.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. There was no information recorded on a named persons for anyone in the unit. This was due to capacity issues of those in the unit and their understanding of the named person process.

Welfare guardianship under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) was in place for eight individuals on the unit. There were copies of the guardianship orders in the files that we reviewed.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment follows the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. All s47 certificates were on file and all but one had a treatment plan; this was in the process of being updated.

There were two people who were subject to covert medication arrangements when we visited the unit. The relevant covert medication pathway and paperwork for this was in place.

Rights and restrictions

The unit had a locked door policy in place that provided a safe and secure environment for the individuals on the unit. This was displayed in an accessible-read version at both the outer and inner entrance to the unit.

We heard from individuals and families that there was good access to advocacy services and people already had an advocate in place. Those that we spoke with told us they found this to be of great benefit and helped them understand the processes of their care. People also told us advocacy spoke on their behalf at difficult meetings and helped explain things after meetings.

The term ‘advance statement’ refers to written statements made under s275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. One person had an advance statement and the paperwork was on file.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is

a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. The paperwork for the two people who were subject to restrictions was in place and reviewed regularly.

During our visit one person was subject to seclusion. On the day of our visit, we found that staff had a good understanding of when their practice needed to aligned with the Commission good practice guide, written for professionals using the seclusion pathway.

The Commission has published a good practice guide on the use of seclusion.

We discussed with the team about their use of seclusion, in the context of an approved policy on the management and prevention of violence, produced by the relevant NHS board for each hospital. We recognise that at times, seclusion may be necessary and services must ensure that it is properly monitored with the aim of reducing risk and preventing harm. The principles of least restriction and benefit to individuals must always be applied and it is also important to support and debrief the person after an incident of seclusion. When reviewing the care of the individual who was subject to seclusion, there was a detailed seclusion care plan which was reviewed accordingly.

Activity and occupation

Various activities and occupation took place in the unit over a seven-day period and these were tailored to each person.

We saw individual activity plans that were person-centred, delivered positive outcomes for the person and were aligned with individuals' care plans that were regularly reviewed. The staff, individuals and families we spoke with were complimentary and positive about the activity and occupation available in the unit.

We heard that while there was no current activity co-ordinator post in the unit, the management team recognised the importance of this post and intended having a dedicated coordinator going forward.

We noted there was OT input from Tuesday to Friday. The OT staff offered assessment of functional needs, supported people to re-engage in meaningful activities, promoted social inclusion, supported confidence building, budgeting, and shopping.

We saw evidence of the activity and outcomes of this documented by OT staff on MORSE. We also noted that nursing staff provided various activities in the unit throughout each day. The OT staff devised an activity timetable for each person that was documented in the unit diary. This included input from individuals in the unit who had identified their preferences and interests.

The activity timetable included a wide range of activities such as a community social group, external health and fitness groups, walks, and visits to local places.

During our visit, we saw people enjoying quiet time watching television and some individual art sessions taking place. We also saw people enjoying the garden area and leisure equipment that was available, with nursing support. We noted families that attended the unit were helping to provide support out into the community.

The physical environment

On entering the foyer at the Kylepark building, we found it to be clean, with a sense of calm and quiet.

We heard from relatives and people in the unit that they found the level of cleanliness to have a positive therapeutic effect. In the unit, there were four corridors that had been designed to consider the needs of all. Each corridor had three bedrooms with a separate lounge/dining activity area, with direct access to their own outside space that had robust garden furniture and exercise and relaxation equipment.

We heard the gardens were open during the day when the weather was good and were told that people like the outside space. We saw people purposefully walking and using the equipment in the garden areas. We were also aware from care records that the garden area was risk assessed on an ongoing basis for each person, to ensure that the area was safe and staffed appropriately.

All bedrooms were single rooms and had showering facilities that were in good order. We noted that the frosted privacy coverings on two windows in bedrooms required to be replaced. This had been reported, and the rooms were waiting for replacement coverings. One of the bedrooms with its own garden area was damaged and was waiting to be repaired. The room was minimally decorated and furnished, due to the requirements of the person's care needs, which were documented and risk assessed.

We heard there had been a recent reduced ligature audit completed, which was a regular occurrence in the unit, to balance the needs of each person's care. We were also informed of three-monthly environmental audits that took place.

We noted the completion of a purpose-built extension that adjoined the unit for an individual with complex needs. This was an innovative addition and a forward-thinking approach to supporting the most complex people, where it had been difficult to find an appropriate community placement; this work is sector leading and will allow the health team and local authority partners to source an appropriate provider for the individual. It will also ensure the individual is able to

move on from the unit in a planned and supportive way that should help to enhance their life experience.

Any other comments

We heard of strong partnership working across disciplines to achieve successful dental procedures for people who have a severe learning disability and autism. This is a complex area of work that often goes unmet due to the level of perseverance and planning needed, which is to be commended.

In addition to this, we heard of work that had been successfully completed to transfer a person with complex needs to an acute hospital when they were physically unwell. This had allowed care in the most appropriate setting while keeping the challenges for the individual and staff to a minimum, to accommodate and provide urgent physical health care.

Summary of recommendations

Recommendation 1:
Managers should ensure psychology notes are recorded to the same standard as other professionals to ensure clarity for all involved in a person's care.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia, and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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